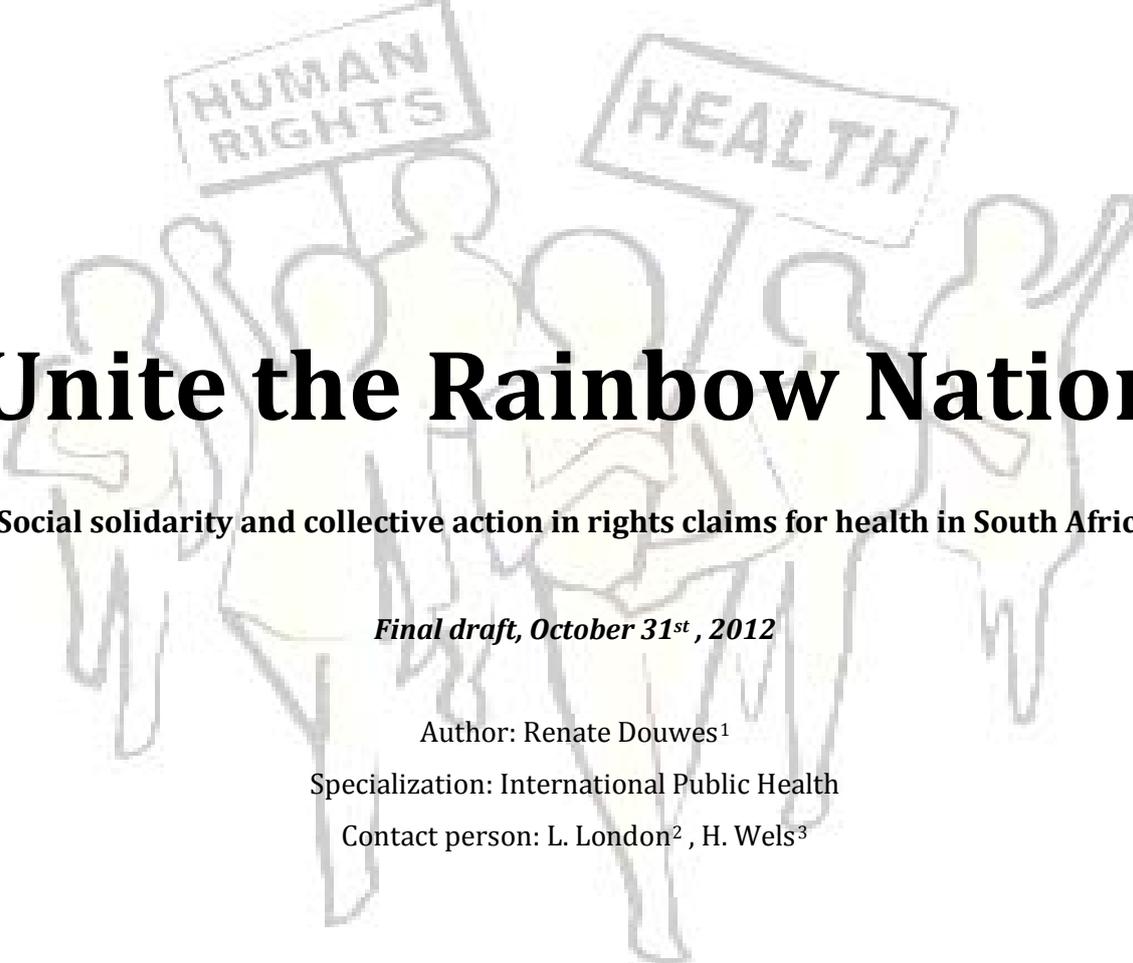




Internship report Renate Douwes (2083795)

Management, Policy-Analysis and Entrepreneurship in Health and Life Sciences



# Unite the Rainbow Nation

Social solidarity and collective action in rights claims for health in South Africa

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Author: Renate Douwes<sup>1</sup>

Specialization: International Public Health

Contact person: L. London<sup>2</sup>, H. Wels<sup>3</sup>

<sup>1</sup> Correspondence: [renatedouwes@hotmail.com](mailto:renatedouwes@hotmail.com)

<sup>2</sup> University of Cape Town-Public Health Department ([l.london@uct.ac.za](mailto:l.london@uct.ac.za))

<sup>3</sup> VU University Amsterdam ([h.wels@vu.nl](mailto:h.wels@vu.nl))

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The research that lead to this report has taken me to the beautiful country of South Africa. It was a first time experience for me, one that I will never forget. Hopefully I will return soon. During my research I received help on multiple levels. Therefore, I would like to express my gratitude to everyone who offered my their help. First of all, I would like to thank the staff of the Public Health Department at the University of Cape Town, and especially Prof. London, for giving me the opportunity to conduct research on their behalf. The research was conducted with help from the civil society organizations affiliated with the Learning Network. I would like to thank the spoke persons of these organizations for helping me organize the focus group discussions. The participants deserve a special thank you here as well; since this research would have been useless without them. I thank them for sharing their multiple stories and experiences with me. And last, but not least, I would like to thank my supervisor of the VU University for his feedback and support.

## **Abstract**

### *Introduction*

Collective action for the right to health is currently not happening in South Africa. Since the establishment of a formal democracy in 1994 after the Apartheid era, several policies and institutions were directed at promoting human rights. However, the realization of the right to health for every citizen in South Africa is lagging because of inequalities in health status and in distribution of resources that still remain visible nowadays. This research aims to provide insight in experiences of the South African Western Cape population with social solidarity and collective action for claims to the right to health by exploring the concepts of trust, altruism and reciprocity. This leads to a better understanding of human rights based approaches to health in South Africa.

### *The right to health in South Africa*

The right to health refers to the WHO standard of the enjoyment of the highest attainable standard of health. South Africa ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) that consist of several elements like access to medical care, safe drinking water, adequate sanitation, and education. Furthermore, it includes the right to be free from discrimination and unwanted treatment. The right to health has been violated for many years during the Apartheid era in which moral and ethical codes of practice were neglected. After the apartheid period humanity and dignity were key components in the new government policies. However, inequalities in health status and distribution of resources persist. A tool for achieving universal access to health is a human rights based approach to health. This approach applies a human rights framework, with concepts like equity, equality and non-discrimination, to health and health care provision.

### *Methods*

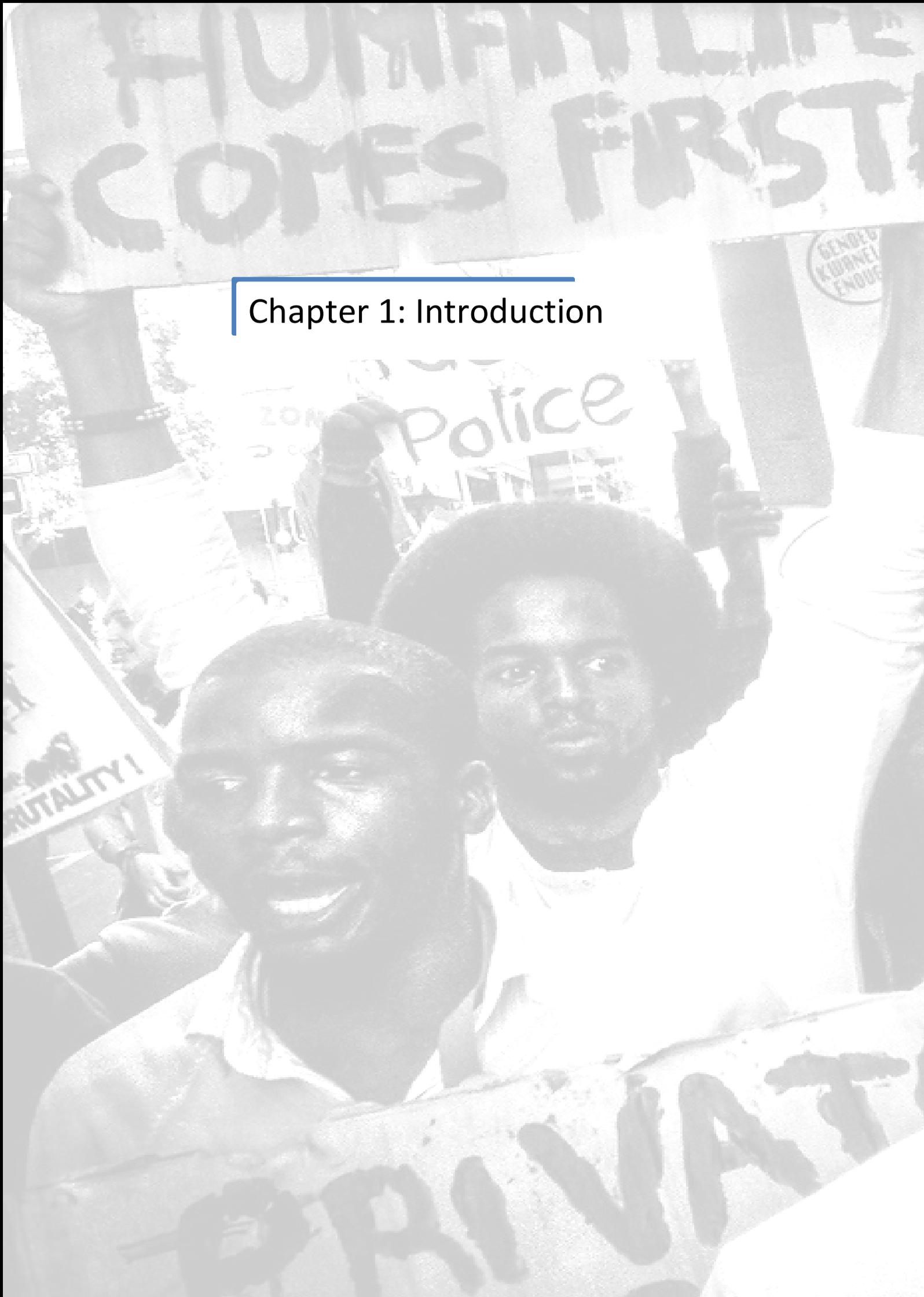
Focus group discussions and interviews were held to gain insight in views and beliefs about how the concepts trust, altruism and reciprocity, that are related to social solidarity in a social capital framework, can contribute to collective action for the right to health. Participants were approached by contact persons of civil society organizations affiliated with the Learning Network for Health and Human Rights.

### *Results*

This research showed that without trust collective action through social solidarity will be hard to achieve since it became clear that a basis of trust is important in all concepts explored in this research, e.g. altruism and reciprocity. Furthermore, reciprocity is considered to be the best option for collective action for rights claims. To achieve the right to health and to provide everyone with a standard of living adequate for the health and well-being of himself and of his family, reciprocity, which must include a bases of trust, can be used for the redistribution of resources. Favours and sacrifices made, can be reciprocated to benefit everyone.

### *Conclusion*

Trust can contribute to collective action if individuals in society are willing to use and install it. Important is that trust should not only be used within their own community or for friends and family, but also within larger society and for strangers. This derives from the recurring subject of social distance and anxiety for strangers. Putting trust in strangers can contribute to a feeling of solidarity and can reduce social distance; both needed for society to stand up and fight collectively for their right to health. Trusting others can help overcome differences and problems of the past. Trust was seen as a basis for the other concepts, which shows the interrelatedness of the concepts. Altruistic acts were believed to be only performed within close circles. Altruism can contribute to collective action by reducing social distance since it will lead to a stronger feeling of solidarity and a greater willingness to commit to others. This research showed that reciprocity is considered to be the best option for collective action for rights claims. Reciprocity can contribute to collective action if individuals reciprocate favours they've received, in the context of the right to health, to others. This can range from a small advice where to go when your rights have been violated, to contributing to a large health care scheme.



## Chapter 1: Introduction

## **Chapter 1: Introduction**

*'If we can work together, all of us, South Africa would be beautiful'*. Thus stated one of the participants when she talked about problems with drugs and a lack of jobs in South Africa during a focus group discussion in Khayalitsha, one of the largest townships in Cape Town. In a small room of a civil society organisation located in this township, ten *'African mama's'* were present, willing to discuss their views and experiences about issues of trust, reciprocity and altruism in the South African society. According to these wise mama's problems can be solved if different communities work together; if they all form a united front and speak with one voice. However, they also mentioned that this collective action is currently not happening in South Africa. In this report collective action in the context of claims to the right to health is addressed. The right to health, one of the socio-economic rights, has been formulated in article 27 of the South African Constitution (The Constitution of the Republic of South Africa, 1996). In this article the right to access to health care services and safe water and food are pointed out. The South African constitution is considered to be one of the most progressive rights oriented constitutions in the world (Albertyn, 2006). Since the establishment of a formal democracy in 1994 after the Apartheid era, several policies and institutions were directed at promoting human rights. However, the realization of the right to health for every citizen in South Africa is lagging because of inequalities in health status and in distribution of resources that still remain visible nowadays (Terreblanche, 2002; Ntuli and Day, 2004). For the realization of this right to health for everyone, social inequalities need to be diminished. For the most vulnerable individuals and communities in South Africa, knowledge about their entitlement to the right to health is not present. With this knowledge these communities could engage in civil society action and fight for their rights, especially the right to health. In this report this kind of collective action will be explored. Furthermore, the concept of social solidarity will be explored because the implementation of a national health insurance system, a step forward in accomplishing the right to health for all, can be seen as an intervention that is heavily relying on this feeling of social solidarity. Whether a health insurance system succeeds or fails depends on the willingness of South African people to see health care as a concept of social solidarity, seeing it as collective construction rather than an individualist one. For this report associated concepts of social solidarity will be used; trust, altruism and reciprocity (Komter, 2003, Putnam, 1993, Coleman, 1988). When people trust each other, more willingness to join voluntary organizations and to engage in collective action is likely to exist (Uslaner, 1999). Altruism means placing what is good for others above what is good for oneself and comprises a moral obligation to sacrifice oneself for the collective good (Campbell, 2006). Reciprocity differs from altruism since reciprocal actions comprise expectations of future rewards where altruism does not contain these. Reciprocity promotes solidarity according to Putnam (1993)

by generating goodwill. A strong reciprocal bond strengthens communities in a pursuit of the common good (Fong, 2011).

This research was conducted in the Western Cape of South Africa; in Cape Town and surroundings, e.g. the large township Khayalitsha. For this report the Public Health Department of the University of Cape Town formed the basis from which the fieldwork started. The Public Health Department is involved in a Learning Network for Health and Human Rights. This Learning Network is composed of six civil society organizations and four universities, collaborating to explore how

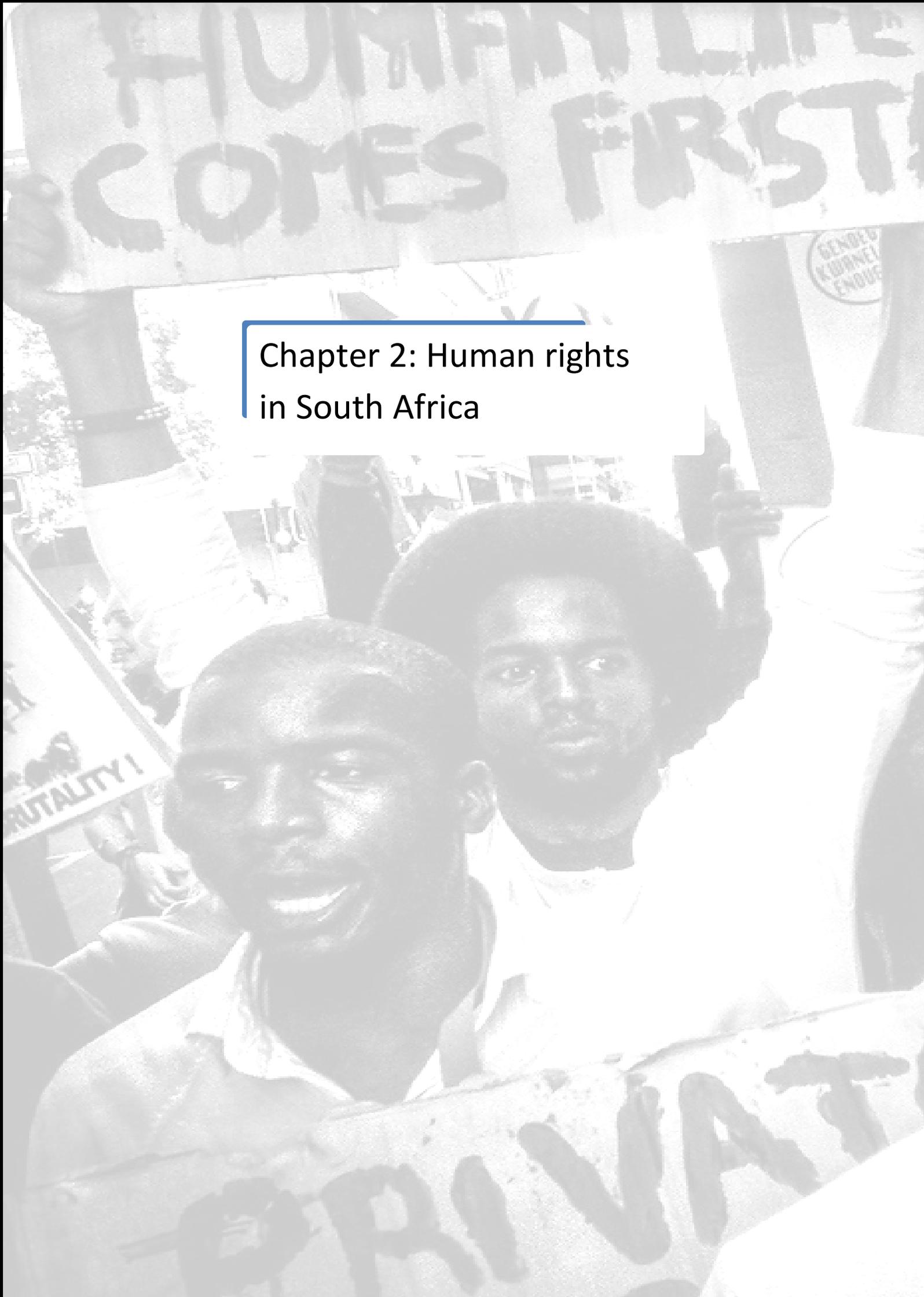


Figure 1: South Africa (wikitravel.org)

collective action and reflection can identify best practice with regard to using human rights to advance health (<http://slearningnetwork.weebly.com/index.html>). The Learning Network is conducting research on Human Rights and rights based approaches to health, but also offers seminars and workshops. Besides this, the Learning Network has made a toolkit, designed in response to the need for a practical tool to empower communities on what the right to health means, how to identify violations of health rights and how to respond to these violations. This Learning Network offers the opportunity to gather information from their members and is therefore used in this research to provide the study population. The members of this network come from different layers of the South-African society. Members can be staff who work for the organization, volunteers or beneficiaries of the organization's services.

### Research objective

This research aims to provide insight in experiences of the South African Western Cape population with social solidarity and collective action for claims to the right to health by exploring the concepts of trust, altruism and reciprocity. Since these concepts are important in human rights based approaches to health, claims for the right to health can be done within a human rights based framework. This research will provide insight in how these concepts can contribute to collective action for the right to health in South Africa within a human rights framework.



## Chapter 2: Human rights in South Africa

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### The right to health

The right to health is a common used phrase in human rights language. The right to health refers to the WHO standard of the enjoyment of the highest attainable standard of health (World Health Organization, Constitution, 1946). As Leary (1994) states, the phrase 'right to health' may be incomplete as it comprises the right to health protection including the right to health care and the right to healthy conditions. In the Universal Declaration of Human Rights the foundation for all human rights is laid (United Nations (UN), UDHR, 1948). This declaration provides a set of internationally agreed upon standards that guide governments in establishing their laws. It states that all human beings are born free and equal in dignity and rights. The declaration includes rights like the right to non-discrimination. Furthermore, it states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services (UN, UDHR, 1948). Besides this declaration, that is guiding but not binding, covenants exist that provide legally binding agreements for those countries that ratified it. The International Covenant on Economic, Social and Cultural Rights (ICESCR) is one of these covenants. It includes the right of everyone to enjoy the highest attainable standard of physical and mental health, also known as the right to health. Almost all countries have ratified this binding treaty and many included this right in their national constitutions (UN, ICESCR, 1966). The right to the highest attainable standard of health, or the right to health, consist of several elements like access to medical care, safe drinking water, adequate sanitation, and education. Furthermore, it includes the right to be free from discrimination and unwanted treatment (Committee on Economic, Social and Cultural Rights (CESCR), 2000). For the right to health to be established, a good working and accessible health system is required. This system must be effective, responsive and of good quality. Every individual and every community should have the opportunity to participate in the decision making on health issues that affect them (Hunt, 2008). In 2000 the UN Committee on Economic, Social, and Cultural Rights adopted general comment 14 (CESCR, 2000). This comment contributed to a deeper understanding of the right to health and made this right operational. It provides a common language for talking about health issues, that makes it easier for policy makers and governments to discuss. It states that all health facilities and services should be available, accessible and acceptable (Hunt, 2005). Availability, here, means that health care facilities should be available in an adequate number throughout the country. However, the quality of these facilities can differ per country; one can expect better quality hospitals in a high income country with more resources. Availability does not necessarily mean that treatment is accessible to all. In remote areas access to medicines might not be present or not be affordable to everyone, especially for the

poorest who can't afford travel or medicine costs. Furthermore, the level of the given health care services should be culturally acceptable for all citizens, for example sensitive to gender and culture and with respect to medical ethics (Backman, 2008). The General Comment 14 also constitutes actions that governments should fulfill and protect. These actions include providing entitlements for health and healthy conditions for all citizens, as well as access to health care services. Governments should not only install a health care system, but they should pay attention to the underlying determinants of health such as safe drinking water and sanitation as well (UN, CESCR, 2000, paragraph 11).

## **Human Rights in South Africa**

### *A history of human rights*

Human rights have been violated and neglected in South Africa in the history of colonization and Apartheid. Especially the right to health has been violated for many years during the Apartheid era in which moral and ethical codes of practice were neglected. As Terreblanche (2002, p.3) argues; 'if one wishes to understand contemporary South Africa, one must have a sense of its history'. From 1652 onwards, when the Dutch East India Company settled at the Western cape of South Africa, the black population of South Africa has been struggling to fight the inequalities they have suffered from. Throughout history South Africa has known multiple conflicts, violence, warfare and plunders with different ethnic and racial groups that tried to enrich themselves at the expense of others (Terreblanche, 2002). The conflicts started when indigenous people were forced by colonist to leave their land and work on settler farms. Furthermore, slaves were imported from West Africa, Mozambique and India to work on these farms. After this, the British occupation began and the Dutch settlers known as the Boers moved north occupying even more land of natives (South African history online, 2011; Terreblanche, 2002). After the Boer-war between British and Afrikaner (Dutch) occupiers, both parties ruled the land together in the Union of South Africa keeping all power into the hands of whites.<sup>4</sup> When diamonds and gold were discovered an influx of British migrants occurred and further subjugation of natives to work in the mines was carried out. Mining became the cornerstone of the South African economy and still constitutes a substantial part of the economy nowadays. In 1912 the African National Congress (ANC) was founded. The ANC promoted the reduction of restrictions based on color. However, the government continued to establish laws limiting the rights and freedoms of black inhabitants (South African History Online,2011).

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<sup>4</sup> In this report a distinction is made based on race, since this distinction is still made in South African society nowadays. This is not done out of any discriminatory reasons.

### *Apartheid and human rights*

In 1948 the National Party instituted an apartheid policy, or racial separation, which favored the white minority above the black majority. The Apartheid policy politically excluded black inhabitants. A system of racial classification was introduced in 1950 through the so-called Population Registration Act, separating people from birth into different races; white, indian, colored and black (Posel, 2001). This act was formed out of the National Party's ideology of 'racial purity' (Posel, 2001). A national population register was established in which the racial classifications were recorded. This register contained other information about residence, employment, marital status and entitlements to social security as well (Posel, 2001). A fragment of the Population Registration Act:

*A white person is one who in appearance is, or who is generally accepted as, a white person, but does not include a person who, although in appearance obviously a white person, is generally accepted as a coloured person. (Section 1 [xv],)*

*A "native" is a person who is in fact or is generally accepted as a member of any aboriginal race or tribe of Africa. (Section 1 [x])*

*A coloured person is a person who is not a white person nor a native. (Section 1 [iii])(Union of South Africa, 1938).*

The system determined where people could live, work, and receive education or whether they could vote (Terreblanche, 2002). The Group Areas Act in 1950 sanctioned a relocation of approximately 3,5 million inhabitants to rural homelands or so-called Bantustans (Baldwin-Ragaven *et al.*, 1999). It determined the amount of resources allocated to education and health for the different classes as well. Black people were forced to wear permission passes for work and residency in urban areas that were full of 'whites only' signs. The apartheid policy was reinforced by state control and repression (Terreblanche, 2002; South African History Online, 2011). These policies were said to promote the development of different races in their own separate geographical area. However, the government controlled all facets of the society exploiting non-white citizens for the gain of the white minority (Naylor, 2004). Other acts that banned public gatherings and protests were installed, said to safeguard public safety, instead these acts enabled the government to detain people and ban organizations (Naylor, 2004).

During the Apartheid era major violations of human rights occurred in many ways and on different levels. These systematic and coarse violations deprived the black and colored population of its rights, e.g. the right to self-determination, freedom of movement and the right to non-discrimination. Apartheid was built on discrimination, denial and segregation in every area; social, political and economical. The International General Assembly (resolution 2202 A (XXI) of 16 December 1966) and Security Council (resolution 556 of 23 October 1984) stated that the apartheid was a crime against humanity. Several international conventions and declarations were violated, like the Universal

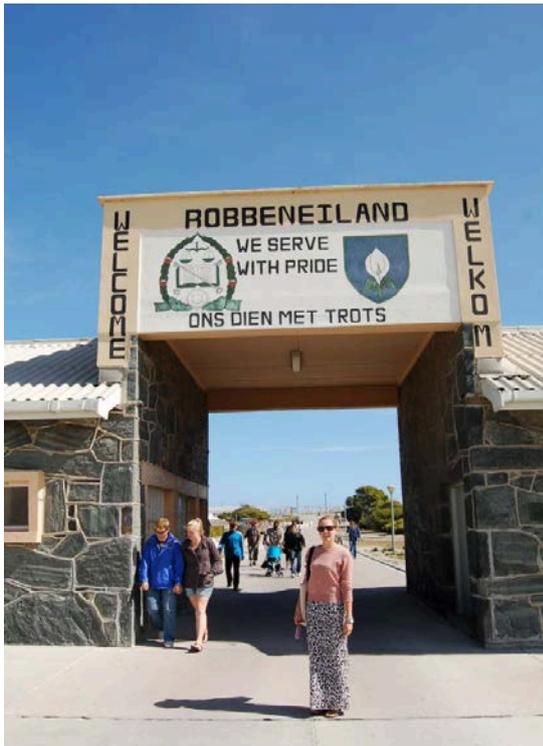


Fig 2 Renate Douwes in front of Robbeneiland April 9<sup>th</sup> 2012

Declaration of Human Rights. The South African security forces were notorious for the torturing of detainees in for example the Robbenisland prison. Torture, murder, rape, mutilation, disruption of social life and structural violations of dignity were pressed upon the deprived majority (Sideris, 1998). The state used these severe methods to suppress protest and rebellion among the deprived majority. The established acts enabled the security forces to act against individuals whose activities were considered to be endangering public peace; a definition of this term was very open so that it could be used freely (Naylor, 2004). Police violence was well known in case of protest or marches against the regime; tear gas, whips, batting stick, dogs and guns were

frequently used (Naylor, 2004). After the Apartheid, stories of women who experienced rape, vaginal examinations and body searches during detention came out. Pregnant women were beaten and given electric shocks during their imprisonment (Sideris, 1998). It was estimated that between 1974 an 1979 alone, a total of 946 African and colored individuals were killed and 2558 injuries occurred (IDAFSA, 1983).

Just as many rights, the right to health has been neglected during the Apartheid era. The Apartheid policies resulted in major disparities in living conditions and access to state facilities. The basic determinants for good health such as adequate shelter, sanitation, education and political freedom were lacking for the deprived majority. The health status of this population, accounting for 83% of the South African population, was poor compared to the status of the white dominating population. Policies of the Department of Health in that time were not in the best interest of the well-being of all South Africans, rather they were driven by the ideology of the state (Baldwin-Ragaven *et al.*, 1999). The health system was racially separated with different health services for each group. Health care provision was fragmented and unequally distributed over different classes and between rural and urban areas with their provision being biased towards white areas, whilst rural and township areas were under-funded. Furthermore primary care and district hospital capacity had been neglected and most resources were allocated to hospitals in urban areas (Bloom, 1998 and McIntyre *et al.*, 2007). The health conditions in the Bantustans were very poor due to poverty and a lack of hygiene. The health care facilities within these Bantustans had to cope with shortages in resources, e.g. doctors and finances. These facilities however, had to deal with the epidemic of ill

health of the people living in the Bantustans (Baldwin-Ragaven *et al.*, 1999). The majority of the population did not have access to an acceptable level of health care and could not get the same quality of care as the white population, since the Apartheid segregation was also instituted in hospitals (Terreblanche, 2002). An example of this is the Red Cross Hospital in Cape Town, where separate entrances and treatment areas for 'white' and 'non-white' were instituted. Apartheid policies were also visible in blood transfusions and ambulance services. Blood used for transfusion would be tagged so that whites would not receive blood from a black person. Ambulances only carried patients of one racial group, also in case of emergency (Baldwin-Ragaven *et al.*, 1999). The rights of patients, and thereby their dignity, were violated on many occasions and in many ways. Examples of this include doctors who allowed security forces to take medical records, who certified a prisoner fit for torture, who failed to record injuries or who prevented family to access patients. Furthermore, cases of medical doctors who played a role in the torturing of political activists are known (Baldwin-Ragaven *et al.*, 1999). Because of these policies, patterns of racist behavior among health professionals were established and furthermore, these patterns became normal. In the years after the Apartheid, these patterns still exist and stay an important issue in health care provision. Major inequities remain visible, especially in rural and remote areas with limited access to health care facilities (Baldwin-Ragavan *et al.*, 1999, Terreblanche, 2002).

International protests and boycotts, as well as national mobilization and opposition by civil society groups led eventually to the abolishing of the apartheid. This led to the first democratic elections in 1994 in which the ANC came to rule with Nelson Mandela as president. The following period was dominated by reform, aimed at reducing inequality and stabilizing the economy. The Truth and Reconciliation Commission (TRC) was created to promote national unity after years of conflict (Valji, 2004). Victims of human rights violations were invited to give statements about their experiences, some of them during public hearings. Besides this, perpetrators of these violations could give testimony and request amnesty from both civil and criminal prosecution. Reconciliation was promoted this way. However, racial prejudice and violence did not disappear after 1994 and continue to play a role in politics. Equality and inclusive citizenship for all still remain absent (Valji, 2004). The shooting during the mine workers strike in Marikana this August reopened old wounds since this act of violence had so much resemblance with the violence that occurred during the Apartheid era. Miners were striking for a raise in salary since they felt exploited by the mining companies; the high profits do not match the low wages. The police opened the fire on the striking mine workers; in the violence that followed 36 mine workers and 2 police officers were killed. An ironical comparison of the ANC government to the Apartheid regime was made; this proclaimed 'massacre' was the most lethal use of force by the South African security forces since the end of the apartheid era (South African Press Agency, 2012).

## **The South African constitution**

After the apartheid period humanity and dignity were key components in all new government policies. The ANC government introduced several laws that promoted a non-racial society. In 2001 the government however stated that racial inequalities are not an isolated problem that will be solved by equal application of the law, instead a complete transformation of society is necessary to reduce these inequalities (Terreblanche, 2002).

A new constitution was written by the new government. South Africa adopted the right to health in this national constitution. This constitution (No 108, 1996) contributes to the right to health by guiding the government into the realization of both civil and political rights (e.g. right to life and equality) as well as social and economical rights (e.g. education, health care and housing) (The Constitution of the Republic of South Africa, 1996). The constitution's underlying values are the achievement of equality, non-racism and non-sexism in a system with democratic governance that is open, responsive and accountable (The Constitution of the Republic of South Africa, 1996, Art. 1). Article 27 of this constitution states that everyone has the right to access to health care services including reproductive health, sufficient water and food, social security and social assistance. Furthermore, it mentions that the state must undertake reasonable legislative and other measures to achieve the progressive realization of these rights, within its available resources. Another important point is that no one must be refused emergency medical treatment (The Constitution of the Republic of South Africa, 1996). The South African Constitution includes a Bill of Rights, which is considered to be one of the most progressive in the world because it includes both social and economic rights (Liebenberg 2007). This Bill of Rights was adopted as supreme law to redress the systemic socio-economic discrimination and deprivation experienced by the black population during the Apartheid and colonial eras. It encompasses the rights to life, dignity, health care, and reproductive choices. Furthermore, a basic level of socio-economic resources, considered to be fundamental for the enjoyment of many other civil and political rights, is defined in the Constitution (Liebenberg, 2007). As Nelson Mandela (1991, p12.) stated: 'We do not want freedom without bread, nor do we want bread without freedom. We must provide for all the fundamental rights and freedom associated with a democratic society'.

## **Health care system and health inequalities**

After Apartheid the state has worked towards the realization of the right to health by aiming to reduce discrimination and underdevelopment of the system and promoting equity and priority for vulnerable groups (McIntyre *et al.*, 2007). However, despite the promise of the Constitution and many years of democracy, inequalities in health status and distribution of resources persist and the practical realisation of the right to health remains elusive (London, 2012). This can be seen in for

example the maternal mortality ratio which has doubled between 1990 and 2008, which means the Millennium Development Goals will not be met by South Africa (London, 2012). Child mortality, that is considered to be an indicator of health care quality, remains at the same level as in 1994 (London, 2012). Differences between races in disease and mortality rates and access to basic living conditions and other determinants of health can be identified (Coovadia *et al.*, 2009). For example, South Africa has one of the highest rates of HIV prevalence with the highest prevalence among the black population (Shisana *et al.*, 2005). Differences between men and women are also evident; mortality is 1,38 times higher in men than in women (Bradshaw *et al.*, 2003). Resource availability is unequal in the public and private sector with less than 15% of the population being member of a private scheme to which 46% of all health care expenditure is attributed (McIntyre *et al.*, 2007).

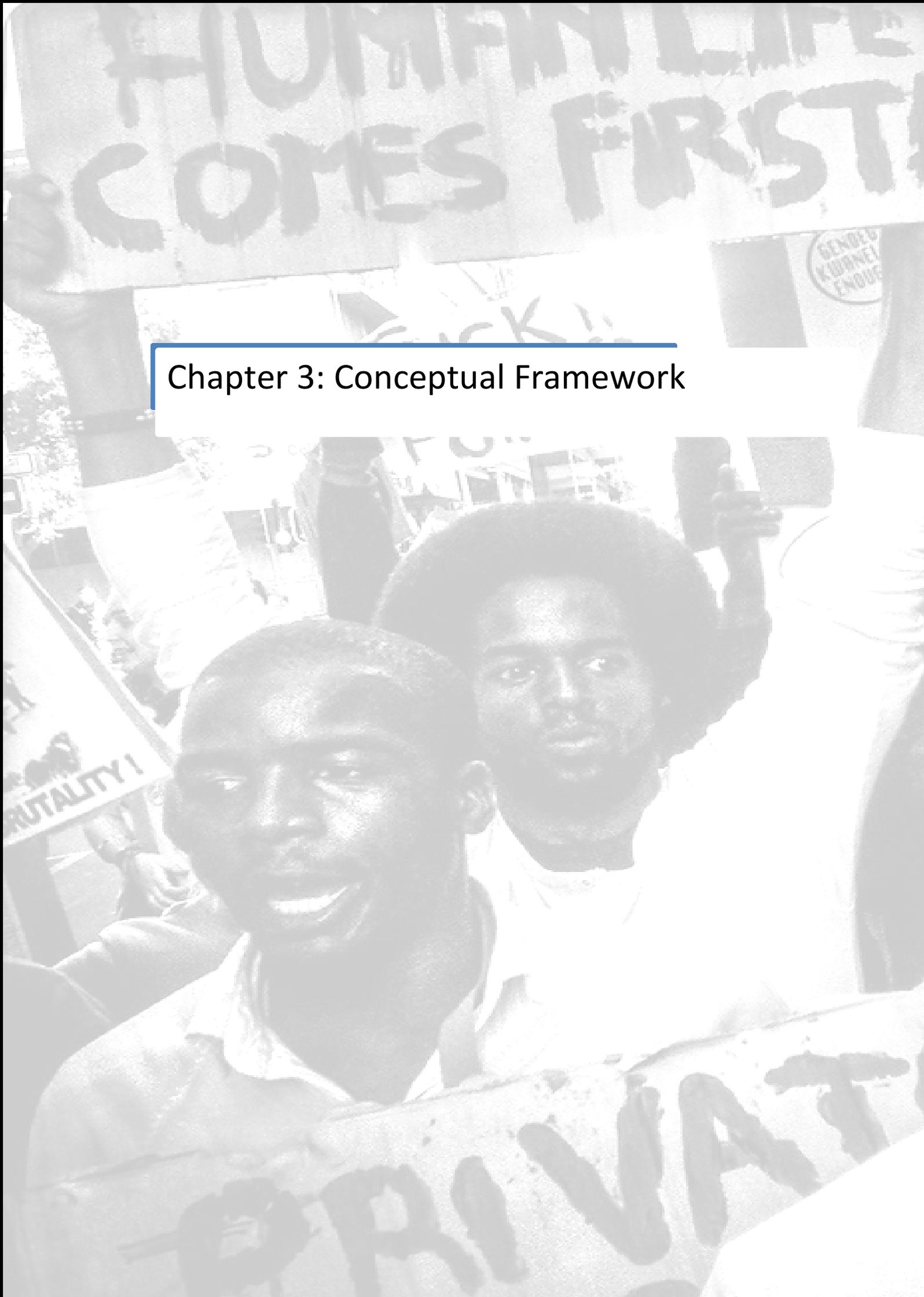
South Africa has to deal with a so-called 'quadruple' burden of diseases which weighs heavily on the government expenditures: HIV/AIDS, non-communicable diseases, poverty related conditions like infectious or parasitic diseases and injuries are all common (Bradshaw *et al.*, 2003). The patterns of economic inequality are reflected in the patterns of inequality in health. A strong relationship between health and socio-economic status can be identified (Bradshaw *et al.*, 2003; Terreblanche, 2002). The poorer groups have lower access to prevention and treatment of these diseases, especially in rural areas. Poverty makes individuals more vulnerable and poverty is related to a higher susceptibility to diseases as HIV/AIDS, which cause even more impoverishment (Terreblanche, 2002, ). The South African health system is a mixed system of private and public financing. The rich minority is covered by private schemes, while the poor depend on the under-resourced, tax funded public sector. The spending on private medical schemes has increased, while the public spending has been stagnant, which has made the gap between these even wider (McIntyre *et al.*, 2007). The public-private mix is considered to be one of the greatest equity challenges in South Africa. South Africa does not have a mandatory health insurance for all, although this has been discussed for years there is little progress in achieving this (McIntyre *et al.*, 2007).

### **A Human Rights based approach to health**

Universal access to health care is a key component in a 'human rights based approach to health'. This approach applies a human rights framework, with concepts like equity, equality and non-discrimination, to health and health care provision (Yamin, 2009). With a human rights based approach society can hold governments accountable for the provision of health care, this means that citizens become aware of their rights and claims their rights by influencing state policies and actors. Violations of the right to health can become visible by using this approach, and redress of violations can be set into motion. As Hunt (2008) argues, the state has a legal obligation to make sure that its health care system is accessible to all citizens without discriminating those who live in poverty and

those who are part of a minority or indigenous group. Women, children, the elderly and people living with disabilities require different health needs to which a health system must be responsive, so equal access as to those who are more advantaged is enjoyed. This element is embedded in the concept of equity, here defined as equal access to health care according to need (Hunt, 2008). Health itself is a human right, besides this, health status reflects the enjoyment of several other rights as well. Social inequalities cause patterns of ill health and disability to exist and they limit the ability of people to participate in society (Yamin, 2009). In addressing the inequality problems, focus should lie on the most vulnerable individuals in society since they experience poor health. In a human rights based approach to health the voice of the most vulnerable individuals in society should be heard which will provide them the capabilities and the choice to stand up against human rights violations in health care provision (London, 2008). Furthermore, in a human rights approach the mobilization of groups into collective action to pressure governments into the realization of the right to health is an important component (London, 2008). Collective action, with a large and stable bases in society is needed for the realization of the right to health. This collective action is dependent upon citizens being aware of their rights and willing to stand up and fight for these rights (London, 2008; Chapman, 2002). Thus, knowledge about the right to health is an important factor in a human rights based approach since individuals will become aware of their entitlements. (London, 2008). Human rights approaches can involve developing policies consistent with human rights, holding states accountable and making violations of the right to health visible. This collective action contributes to shaping state policies that are grounded in public involvement. Civil society and community groups can pursue shared objectives for the realization of the right to health that provide a more powerful base than individual claims, so a sustainable health systems based on equity and social justice can be achieved (Backman et al, 2008; London, 2008). The new constitution and legal action need to be combined with mass mobilization like rights awareness campaigns, protests and marches to establish grassroots pressure on the government to realize the right to health.

This chapter has shown that South Africa has experienced a troubled past when it comes to human rights and the right to health in particular. Although the South African constitution gives high priority to the right to health, an equal distribution of this right is still not established. In the next chapter a conceptual framework will be outlined in which social capital and social solidarity will be explored in how they can contribute to claims to the right to health.



## Chapter 3: Conceptual Framework

## Chapter 3: Conceptual Framework

### Introduction

In the previous chapter human rights based approaches to health and collective action have been discussed. In a human rights based approach to health, the concept of social solidarity plays a crucial role. Social solidarity emphasizes the interdependence between individuals in a society (Durkheim, 1893), which is needed in a human rights based approach in which individuals must feel they make a difference for others. In this report social solidarity will be discussed using the related concepts altruism, trust and reciprocity. These concepts will be explained below. The concepts altruism, trust and reciprocity are found in social capital (Woolcock & Narayan, 2000; Bellemare, 2007). Social capital is referred to, by Bourdieu (1986: 51), as accumulated labor which enables individuals to produce profits by working together. Since this includes collective action and social solidarity a framework is build around this concept. The conceptual framework used in this research (depicted below) uses social capital as main concept in which social solidarity (with reciprocity, trust and altruism) will be placed to explore how this can foster collective action. The aim of this report is to investigate how these concepts can contribute to collective action in rights claims to health. In the conceptual framework the relationships between the concepts are indicated. Reciprocity, trust and altruism will be discussed separately below. However, these concepts are interrelated and intertwined in daily life, as will be explained. The distinction between the concepts is therefore an analytical distinction.

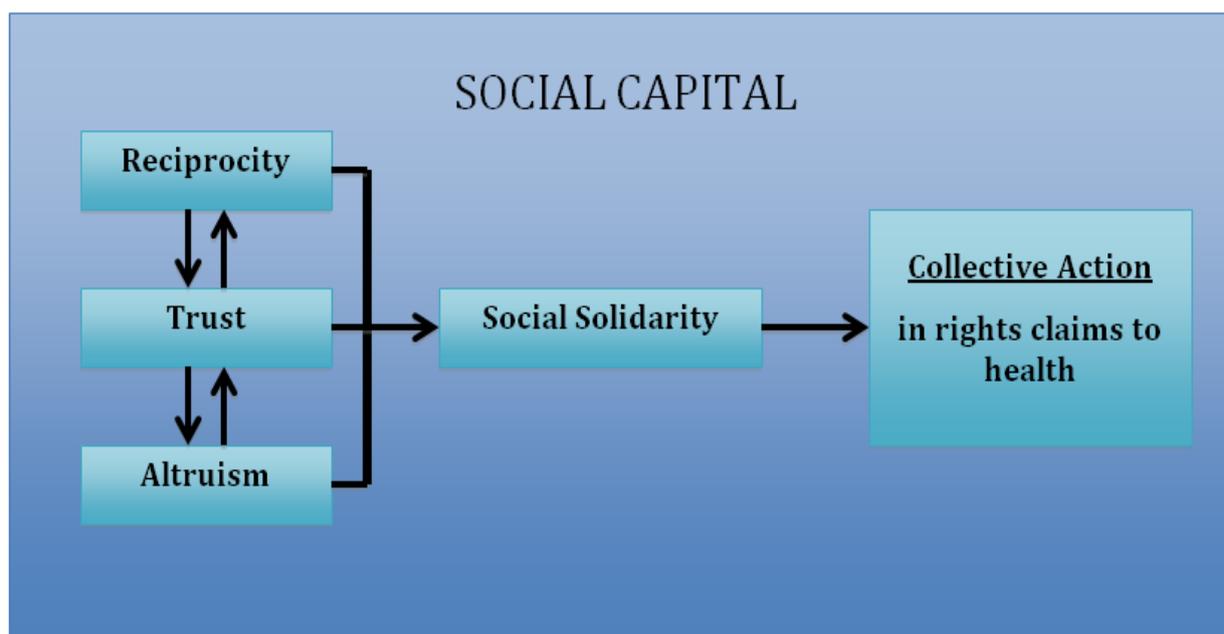


Fig. 3. Conceptual framework. Based on Bourdieu, 1986, Woolcock & Narayan, 2000; Bellemare, 2007

## Social Capital

Social solidarity and collective action can both be identified in the concept of social capital. There are several definitions of social capital, with Bourdieu (1986) as introducer of this concept. He distinguished three different forms of capital; economic capital which is directly convertible into money; cultural capital which is convertible in economic capital or in educational qualifications and social capital which is made up of social connections and relationships (Bourdieu, 1986). In this report only social capital will be used since this is known to enhance collective action (Putnam, 1993). By social capital Bourdieu referred to accumulated labor which enables individuals to produce profits by working together (Bourdieu, 1986). Bourdieu defined social capital as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition” (Bourdieu, 1986: 248). These relationships may be more practical in which material exchanges help maintaining the bonds, or more social in which a common name, e.g. of a family, class or tribe, helps to maintain the bonds (Bourdieu, 1986). The profits derived from membership in a group forms a basis of solidarity. Social capital, he argues, takes time to develop since it is the product of an endless effort of investment in social relationships (Bourdieu, 1986: 52).

After Bourdieu other scholars attended to defining social capital. Woolcock (1998) states that social capital is the information, trust and norms of reciprocity inhering in one’s social network that carry opportunities for mutually beneficial action. Another commonly used definition is from Putnam (1993b: 2): “social capital encompasses the features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives”. Social capital, in short, refers to the system of networks and norms and trust relationships that allow communities to address common goals or concerns (Coleman, 1998, Putnam, 1993b). Woolcock and Narayan (2000) explain that social capital contributes to social development by promoting collective decision-making. They state that social capital refers to norms and networks that allow people to act collectively (Woolcock and Narayan, 2000). Woolcock (1998) argues furthermore that social capital can be divided into ‘bonding’ and ‘bridging’ capital. Bonding social capital occurs in closed networks like families. Bridging social capital connects different types of groups. Bonding social capital networks are inward looking and tend to reinforce exclusive identities and homogenous groups, whereas bridging social capital networks are outwards looking and include people across diverse backgrounds (Woolcock, 1998). As Szreter (2002) states, the bridging social capital is relevant in reducing inequities because it encourages feelings of responsibility for people beyond the bonded group. In this report, the term social capital is used as the set of norms, values or beliefs and trust relationships that are shared within one group or between groups.

Social capital has been linked to health conditions, contributing to health status and lower infant mortality rates (Kawachi et al., 1997). Berkman et al. (2000) state that social relationships and connections amongst communities have a beneficial effect on health. Social capital can promote self-help in communities and allow them to unify themselves in collective action. Participation in civil society movements offers a voice to the participants and can provide the poor with some degree of power. Furthermore, in claiming the right to health, social capital can play an important role in promoting collective action in right claims rather than individual claims.

### **Social solidarity**

The founding fathers of the concept of social solidarity is Emile Durkheim (1893). He was the first to mention this concept in his book *The division of labour in society*, and his ideas are visible in later work of different scholars (Durkheim, 1893). He wondered what the social ties were that hold individuals together. He stated that social solidarity arises from interdependence between individuals in a society and that social integration was founded on shared values and beliefs among different groups in society (Durkheim, 1893). Rehg (2007) extends this by referring solidarity to an element of human association, emphasizing the cohesive social bond that holds a group together in an association valued and understood by all group members. He considers solidarity to be a mode of group cohesion, or group identification, in which shared recognition of a common good holds the group together. This can be a specific value, goal or interest on which members are willing to act on one another's behalf or on behalf of the group (Rehg, 2007). Kenny (2010) identifies with this, he says that solidarity expands the feeling of 'us' to 'us all' and reduces the opposition of 'us' against 'them'. Scholars state that the functions of social capital are only possible when there is a basis of social solidarity and trust towards each other (Bourdieu, 1986, Portes, 1998). According to Komter (2003) the more classical theories of social solidarity emphasize the normative and emotional motives for solidarity, combined with motives aimed at self-interest. An example of the first type of motives is the feeling of belonging with family and friends. Motives based on self-interest are visible in the welfare state; collective gifts are in everyone's own interest (Komter, 2003). In more recent theories a division in motives is visible; on the one side affection and shared norms and beliefs are motives for solidarity, on the other side are rational choice and self-interest (Komter, 2003). According to Komter (2003) the amount of social distance is important in this; affection is more likely to be found in groups with a small social distance like families; whereas motives of self-interest are to be found in larger communities and nations. In the work of Sahlins (1972), discussed in the section about reciprocity, this idea of social distance is visible as well. He makes a distinction between generalized, balanced and negative reciprocity in which he identifies social distance to be an

important factor in reciprocal relationships. The closer the relationship, the more willing individuals are to engage in a reciprocal bond (Sahlins, 1972). More on this on page 31.

The implementation of a national health insurance system can be seen as an intervention that is heavily relying on social solidarity. Whether this health insurance system will work as planned, depends on the willingness of South African people to see health care as a concept of social solidarity, seeing it as collective construction rather than an individualist one. Social solidarity is an important foundation of equitable health care systems in which everyone is willing to pay for health care according to their means and is benefitting from this according to their needs (Harris et al., 2011). In South Africa the needs of the poor are higher than the needs of the rich when it comes to health and the use of health care. This derives from the inequalities in income and resources, see page 12. Therefore, the concept of social solidarity is especially important in the country of South-Africa. A national health insurance system in South Africa will provide coverage and protection for the poorest and most vulnerable individuals (Harris et al., 2011). This requires wealthier people to be prepared to subsidize the health care costs of others and commit their financial resources to benefit the whole community. All South African citizens need to believe that health is a right to which everyone is entitled.

### **Collective action in rights claims**

In this conceptual framework, collective action is defined as the behavior and actions of a group working towards a common goal. All the resources, including knowledge, are used to achieve this goal. In this framework, the common goal is a collective claim for the right to health in South-Africa. In this research collective action is linked to social capital. This is drawn from the social capital framework of Putnam (1993b). He relates social capital to collective unities like communities and associations.

According to Terreblanche (2002) after years of group conflict and systemic violation of the human rights of the majority of the South African population, South African society is still largely divided. The society is currently not one of unity, but consists of separate groups, splintered over different communities (Terreblanche, 2002). These communities do not share the same values and beliefs that are needed for establishing one strong nation. For collective action these shared values and beliefs are needed. Terreblanche (2002) argues that collective action in civil society groups is poorly developed. During the struggle for liberation among the poor black community in the 80's, a large amount of civil society action was present. Unfortunately, this large amount has declined after the elections in 1994 because the main goal, bringing down the apartheid regime, was accomplished (Terreblanche, 2002). The same level of collective action could contribute to equal rights and chances for health by controlling the government and by expressing the will of the people.

In South Africa, examples of how rights violations were turned around by solidarity are known. A well-known example is the Treatment Action Campaign (TAC), an action campaign to ensure universal access to HIV/AIDS-medication, known as anti-retroviral therapy (ART). This campaign was driven by a strong civil society movement, which aimed its collective action at national and international policies. In this way solidarity was translated into governmental policies and judicial orders (Friedman & Mottiar, 2005). The Treatment Action Campaign started as a campaign to promote universal access to treatment for all South Africans in response to the HIV health challenge the country was facing. The TAC started with a small group of protesters in Cape Town on International Human Rights Day in 1998. These civilians demanded the availability of medical treatment for people living with HIV/AIDS (Robins & von Lieres, 2004). The protests grew out to a mass mobilization rooted in a base in which different classes and races were involved (Robins & von Lieres, 2004). Public awareness was raised to develop understanding about the issues of poor availability and affordability of HIV treatment (Friedman & Mottiar, 2005). The TAC became larger and started out against the pharmaceutical companies which blocked the implementation of affordable medication in the form of cheaper generic brands, claiming that this was a trespass of their intellectual property rights. The TAC held very successful media campaigns at global and national level in which it accused the pharmaceutical companies of being responsible for the deaths of millions of Africans due to their corporate greed (Robins & von Lieres, 2004). The pharmaceutical companies surrendered and reduced their prices due to the judicial and social movement pressure invoked by the TAC (Friedman & Mottiar, 2005). During the government of Nelson Mandela, a legislative war was fought between the pharmaceuticals and the South African government that installed a clause that cheaper generic brands should be available (Bond, 1999). However, the next government under President Mbeki was first reluctant to dispense medicines, denying the existence of HIV/AIDS and the efficacy of the medication. Again the TAC, with help from the media, health professionals and civil society organizations, campaigned against these policies by stating before the High Court of South Africa that the government has an obligation to promote access to health (Robins & von Lieres, 2004). The High Court declared that the government denied the people their right to access to health care since the treatment with antiretroviral drugs is a life-saving therapy. Therefore, the government instituted a policy to roll-out HIV treatment at public health care facilities across the whole nation. The TAC is considered to be one of the most successful examples of civil society action for health rights (Friedman & Mottiar, 2005). The TAC activists state that society mobilization, accompanied by (trans) national lobbying and networking, has been the key to their success (Robins & von Lieres, 2004). As Geffen (2001) states, human rights arguments and action alone are not enough; they need to be combined with mobilization of the mass and awareness

raising of the right to health. The TAC mobilization gave hope and support to the most vulnerable and poor individuals in the South African society. It created a new way for citizens to become involved in politics on a local, national or global level. Furthermore, its action moved beyond the country's racial and class division (Robins & von Lieres, 2004).

## **Trust**

The notion of trust has been defined in many ways. Trust is a relational concept that can be instituted between people or between people and organizations (Gilson, 2003). A common understanding of trust is the voluntary action that is based on expectations of how others will behave in the future in relation to yourself (Gilson, 2003, p1454). If these expectations do not match up with the actual behavior of others, negative outcomes like mistrust can be generated. You trust someone merely based on his reputation and former experiences or ability then on his word. Background, culture and social class are considered when determining whether a person can be trusted (Luhmann, 2000). Luhmann (1979, p26-27) states that trust reduces complexity and uncertainty, but that it is also risky to trust someone. Trust involves an element of risk since a person is uncertain about the motives, intentions and future actions of the person he is depending on (Coulson,1998). As Simmel (1950, p318) stated, trust is a combination of knowledge and ignorance, in other words, it is like taking a leap of faith because of the uncertainty of the motives of the other. A strong personal bond in combination with the belief that it raises our own interests is a motivator for trusting the other and for taking the risk (Lane, 1998). Simmel (1950: p318) mentioned confidence to be an antecedent of knowledge; an intermediate between knowledge and ignorance about one's motives. Luhmann (2000) added that confidence does not involve the same amount of risk taking as trust. Someone is confident that his/her expectations will not be disappointed and he/she does not consider alternatives, whereas with trust alternatives are considered and the best option is chosen, with the possibility of being disappointed in mind (Luhmann, 2000). When someone is disappointed in the case of confidence, he will look for an external reason for the disappointment, whereas in the case of trust someone will look at his own decision and regret this (Luhmann, 2000).

Trust includes patterns of openness and reliability. A person, who trusts someone, believes that the other one will, given any circumstances, serve his interests rather than their own. As Luhmann (1979) states, a trustor assumes that the other party will not behave opportunistically. Although no guarantees are given, a trustor chooses to assume that the person to be trusted will not take advantage of his vulnerability (Luhmann, 1979). With other words, the trustor has confidence in his expectations of the other. Based on this assumption, which is the best option since there are no alternatives in a complex world, interaction between people will be established. As Luhmann (1979:10) said; "to show trust is to anticipate the future; it is to behave as though the future were

certain". Trust also involves a moralistic or altruistic expectation of how people should behave and a belief in the goodwill of others. This is rooted in the belief that most people share identical moral values and norms that provide a base for a shared identity (Mansbridge, 1999).

Trust offers benefits for the individuals involved, but also for society as a whole. These benefits derive from the cooperation between individuals that is based on and sustained by a trusting relationship (Coulson, 1998). Trust can break down barriers that prevent cooperation and enhance stable relationships between people (Coulson, 1998). Trust leads to more willingness to join voluntary organizations and to engage in collective action. When people trust each other, an active role in community is likely to exist, which enhances problem solving through collective action (Uslaner, 1999). At the societal level, trust can promote solidarity and tolerance. When trust relationships are incorporated in social structures, such as health systems, it can become a base for a well-ordered society (Misztal, 2001). Trust and shared values can increase feelings of self-esteem and security within and between communities. Furthermore, trust can provide a basis for achieving common goals among organizations with shared values, for example non-governmental organizations (Gilson, 2003).

Trust has been linked to social capital by many scholars (Putnam, 1993; Coleman, 1988; Fong, 2011, Uslaner, 1999) who agree that social capital depends on trust since cooperation, strong relationships and commitments, which are embedded in social capital, cannot exist without trust. Coleman (1988) argues that mutual trust contributes to a form of social capital on which future expectations are based. Putnam (1993) states that networks in a community promote reciprocity, communication and trust, which lead to cooperation for mutual benefit. Both Coleman (1988) and Putnam (1993) agree upon the fact that trust is difficult to produce intentionally; it requires investment efforts to build up and it needs to develop in time, if not already present. As Fong (2011) states, trust facilitates collective action by making community members dependent of each other. This keeps a community stable.

A downside of trust is that it may lead to power relations unfavorable for individuals or vulnerable groups in society. This happens when parties involved take advantages of others or when groups only trust people of their own kind (Warren, 1999). According to Bachmann (2001) a mechanism that shows similar efficiency in reducing uncertainty in social relationships as trust is power. However power doesn't have the same moral value as trust (Bachmann, 2001). In the case of a power relationship the powerful actor selects the possibility that the other will behave the way he prefers not based on assumptions but on sanctions he poses upon the other when the desired behavior is not displayed (Bachmann, 2001). When a power relation breaks down, the effect on personal relationships is less disappointing than the breakdown of trust. This can be seen as an important advantage of power and useful in relationships where trust appears to risky (Bachmann,

2001). But the usability of power depends on whether or not the threat of sanctions is realistic. The power holder uses power to reduce uncertainty in the expectations he has of the other (Luhmann, 1979: 112). This doesn't mean that the other doesn't have a free will; he has alternative options to choose from as well. But the power holder tries to influence the decision to an alternative that suits him best (Luhmann, 1979). However, power does not have a good reputation in a society and therefore doesn't strengthen the social bonds (Luhmann, 1979). Luhmann (1979) suggests power should be used to challenges social structures that are already present.

Trusting others means that people who are considered different are respected. When this is not the case, low tolerance and willingness to cooperate will be a result. A tolerant society will be more open to compromises and collective action for solving problems. Only if people believe others are basically decent, share the same norms or are not looking for taking advantages of them, they are willing to commit to the larger society. (Uslaner, 1999). Shared norms and beliefs between different communities in South-Africa are not present, since patterns of mistrust have been developed in the past (Terreblanche, 2002). In the notion of trust a consideration of the role of group identification is needed since this shapes the individual attitudes towards others in society and perceptions of trust in others. As Parenti (1967) argues, ethnic communities develop social norms which shape the interaction with others in society. Individuals use the norms as a set of values to view and categorize others. When applying the notion of trust to the South African society, one can see that trust between communities has not been present for many years. Patterns of mistrust can be considered throughout different layers in society. Terreblanche (2002) mentions the creation of the idea that the white Afrikaners were endangered by other groups, e.g. blacks. Due to this idea a culture of mistrust was created by displaying 'them' against 'us'. In today's society trustworthiness is still a problem, the poor black communities feel they still cannot see the white population as a companion in their struggle to a better, more equal, society. The other way around, the white population still feels they are blamed and criticized for what their ancestors did (Terreblanche, 2002). Trust is important for establishing a good working health care system as well, since such a system requires cooperation and shared values within society. A health system allows individuals not only to get well, but also to contribute to the well-being of society (Gilson, 2003). Williams (2002) states that trust is of major importance in health promotion activities since these include partners from different sectors and disciplines who need to work together to solve community health problems. In South Africa, with its challenges in the health care sector, trust in each other or in health care officials could foster claims for the right to health.

In this conceptual framework of social capital and social solidarity, the concept of trust refers to whether people feel they can rely on others, e.g. relatives, neighbors, acquaintances, friends or strangers (Jones, 2007). The question whether people will stay true to their beliefs or whether or not

will take advantage of others is also discussed. Reputation and expectations are considered to be important here as well, since the South African society has faced so many trust issues in the past.

### **Altruism**

The concept of altruism is used in different fields of research, e.g. biology, psychology and sociology and is therefore defined by multiple disciplines. First of all, altruism is the concern for the wellbeing of others and considered to be the opposite of selfishness. Pure altruism comprises sacrificing something for someone else, this can be time, energy or possessions, without expecting to receive something in return (Batson, 1991). The French philosopher Auguste Comte, was the first to mention this concept in 1851. He considered altruism and egoism to be opposite motives. He argued that certain behavior reflects an unselfish desire to live for others, this behavior he called altruism (Comte, 1973). In more recent literature Monroe (1996:197) defines altruism as “a behavior intended to benefit another, even when this risks possible sacrifice to the welfare of the actor”. Campbell states that altruism means placing what is good for others above what is good for oneself. It comprises also a moral obligation to sacrifice oneself for the collective good (Campbell, 2006). As Piliavin (1990) contends, altruistic behavior must contain certain conditions; it must be beneficial for the other and voluntarily and intentionally performed, besides this, no reward must be expected. Monroe (1996) explains that altruistic individuals share a certain orientation which allows them to act in an altruistic way. This orientation consists of several components like cognition, expectations, empathy and worldview (Monroe, 1996). Cognition is a process that allows individuals to interpret the world. Expectations may include opinions and beliefs on future situations. Empathy is an affective response towards someone’s feelings. Worldview comprises one’s ideas about the world and oneself (Monroe, 1996).

Social problems can be solved with altruistic behavior, as Sorokin (1950) argues, because it diminishes intolerance, which is an egocentric, self-interested behavior out of a perception that some people are of less worth than others. Altruism promotes cooperation and social integration through harmony and positive emotions such as kindness. It causes distraction from personal emotions and problems and passivity (Sorokin, 1950). Research even suggests that altruistic behavior may enhance health by substituting negative emotions, like fear, anger and preoccupation with oneself, for positive ones e.g. compassion (Post, 2005). Karl Marx already stated that for a group to create a common humanity, the well-being of each depends on the well-being of the whole (Weinstein, 2004). As Sorokin (1950) explains; for a society to survive a small group of altruist is not enough, a society needs multiple, so-called, good neighbors who all donate a small contribution of love. Even trust, which has been elaborated upon, depends for a large part on altruism (Uslaner, 1999). Durkheim (1973) argues that altruism and shared values should lie at the base of social

solidarity to avoid selfish behaviour. Individuals should consider not only their own interests but also their duties to the whole community (Durkheim, 1973). Bellemare (2007) states that altruism is known to be one of the pillars of social capital. In South Africa altruistic patterns of behaviour in communities and between communities are necessary for establishing good relationships on which a new, stable society can be build.

### **Reciprocity**

Putnam (1993) states that reciprocity is assistance to an individual or a group, provided by another individual or group with the assumption that the favor may be returned in the future. Reciprocity is a strong determinant of behavior (Falk, 2006). It contributes to equal relationships. Furthermore, it can produce an obligation to return the favor in the future, which can contribute to a continued relationship between people. Putnam (1993) argues that an act of an individual in a reciprocal system is a combination of 'short-term altruism' and 'long-term self-interest'. Reciprocal behavior comprises a willingness to contribute to the public good and to reprimand those who refrain from contributing (Bowles, 2006). The concept of reciprocity differs from altruism since reciprocal action comprises expectations of future rewards and altruism does not have these expectations.

Reciprocity can contribute to collective action according to Putnam (1993), since it promotes solidarity and shared interests which generate good will for resolving conflicts. In a community, members agree upon with whom they will exchange favors and on what terms. Members will have their own interests, however shared values and emotions will reinforce the reciprocal relationship. Solidarity is promoted according to Komter (2003) since reciprocity requires recognition of the identity of the other. Reciprocity fosters repeated interactions among community members and creates a certain behavior in the future (Putnam, 1993). A strong reciprocal bond strengthens the community in a pursuit of the common good (Fong, 2011). According to Kleinman (1995), reciprocity contributes to health in communities because it structures society, facilitates the fulfillment of obligations and defines moral values which contribute to emotional wellbeing. He states: 'Good exchange is good health' (Kleinman, 1995, p. 220).

Reciprocity can be classified into three different types according to Sahlins (1972). First, generalized reciprocity that is characterized as containing a weak obligation to reciprocate the favor without expectations for immediate return or quality and quantity of this return. The return may even be indefinite (Sahlins, 1972). This reciprocity has an altruistic nature and examples of this type of relationships are found between closely related individuals such as parents and children (Sahlins, 1972, p.194). Parents may not expect a return in the nearby future or at all. However, this does not stop them from giving. The second type of reciprocity is balanced reciprocity, which is characterized as the direct exchange of favors of about the same value (Sahlins, 1972, p.194). There is no delay in

returning the favor here and the relationships between the individuals involved is less strong than in a generalized reciprocal relationship. It is considered to be a more economic relationship in which the material side is equally important as the social side. When a person fails to reciprocate an equivalent within a small time frame, the relationship will be disrupted (Sahlins, 1972). Examples of this type are buyer-seller relationships or peace agreements (Sahlins, 1972). The third type of reciprocity is negative reciprocity in which people will try to gain at the expense of others, for example by thievery or haggling (Sahlins, 1972). This form is the most anti-social form of reciprocity in which individuals confront each other with competing interests, each looking to maximize the benefits at the expense of the other (Sahlins, 1972). Sahlins (1972) states that these three types of reciprocity are related to the amount of social distance, with generalized reciprocity based on close relationships on one side and negative reciprocity with distance between for example ethnic groups and strangers on the other side. Balanced reciprocity lies between these two. Balanced reciprocity comprises a willingness to give for what is received (Sahlins, 1972). A social compact can therefore be established by balanced reciprocity due to a balance between self-interest on the one hand and refraining from hostile intents on the other hand, all in favor of mutuality (Sahlins, 1972). For reciprocity to be established a base of trust is needed according to Simmel (1996). He argues that uncertainty also plays a role in a reciprocal relationship because the actors involved are unpredictable; trust may reduce this uncertainty. If someone has a trustworthy reputation, a reciprocal relationship is easier to be developed (Simmel, 1996).

Reciprocal relationships should always be considered in their historical context. This is especially the case in South Africa where this research will be conducted. Interactions, shared values and norms and reputations between communities play a role in establishing reciprocal relationships. The first chapter touched upon the history of Apartheid in which major inequalities and patterns of mistrust were established. These still play a role in today's society. Negative reciprocity might be felt by the black population, since they were forced to contribute major favors without receiving anything in return. The white population still feels that there is no basis for a balanced reciprocal relationship. However, a balanced reciprocal relationship might be useful in developing relationship that can contribute to collective action. Therefore this research will look into how reciprocal relationships, that exist nowadays, could be beneficial for collective action in rights claims for health.

### **Analytical distinction**

As stated in the introduction, the concepts trust, altruism and reciprocity are interrelated concepts. In this chapter it is shown that the concepts can exist alone and provide a distinct meaning and working mechanism. However, the concepts are also depended of each other in certain situations. For example, a base of trust in society and the goodwill of others is needed for performing an

altruistic act. This interrelatedness makes this conceptual framework complex. In this research an analytical distinction is made in order to reduce this complexity and to give more attention to the differences between the concept instead of their similarities. However, these similarities should not be overlooked.

### **Research question**

After exploring the concept of the conceptual framework, the following research questions can be defined:

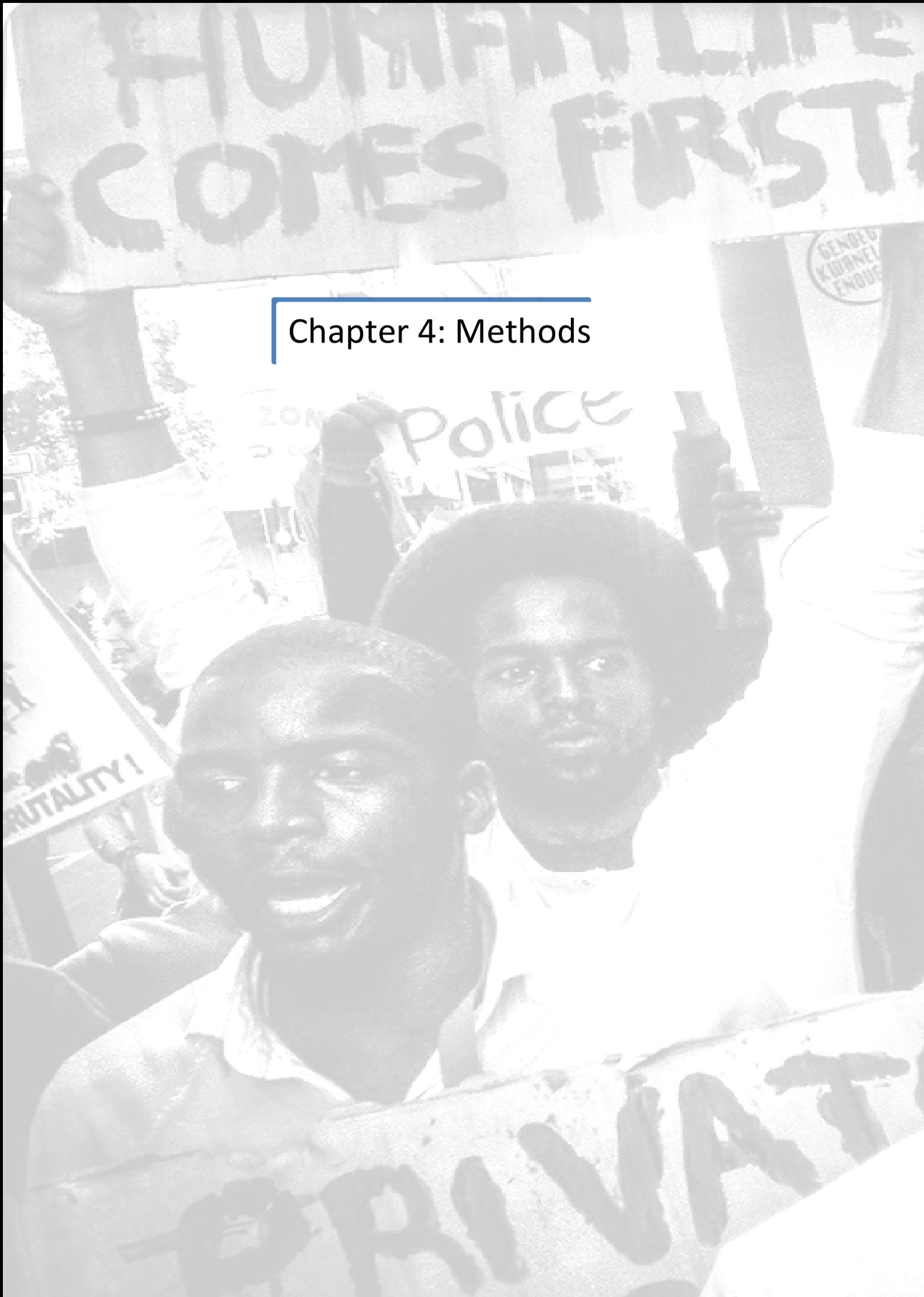
*What are beliefs and views of members of the Learning Network of trust, altruism and reciprocity in the context of social solidarity for collective action in rights claims to health in South Africa and how do they feel, based on their individual experiences, that the presence of these concepts in the South African society can contribute to collective action in rights claims to health?*

### *Sub research questions*

The following sub research questions can be derived from the conceptual framework:

- What are beliefs and views of members of the Learning Network of *trust* in the context of social solidarity for collective action in rights claims to health in South Africa and how do they feel, based on their individual experiences, that the presence of this concept in the South African society can contribute to collective action in rights claims to health?
- What are beliefs and views of members of the Learning Network of *altruism* in the context of social solidarity for collective action in rights claims to health in South Africa and how do they feel, based on their individual experiences, that the presence of this concepts in the South African society, can contribute to collective action in rights claims to health?
- What are beliefs and views of members of the Learning Network of *reciprocity* in the context of social solidarity for collective action in rights claims to health in South Africa and how do they feel, based on their individual experiences, that the presence of this concepts in the South African society can contribute to collective action in rights claims to health?

An answer on these questions will be given in the following chapters of this report. First, the methods will be discussed, after which the results and discussion are set out. Trust, altruism, reciprocity and collective action will be explored separately.



## Chapter 4: Methods

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### **Introduction**

In this chapter the research methods used for this report will be explained. The data collection of this report on social solidarity and collective action in right claims was done by using qualitative methods. The methods of data analysis will be explained subsequently.

### **Data collection**

The first step in this research was an extensive literature search into South-African history and human rights and human rights based approaches to health to build the background and context of the research. After this, the concepts trust, altruism, reciprocity, social solidarity and social capital were explored for the conceptual framework. This was done by conducting a literature search and by discussion and reflection with VU university students and lecturers. This led to an explorative conceptual framework which was open for revision and reflection during the whole research period. The literature study was conducted using several sources; scientific books, journals, scientific articles and internet databases like Google Scholar, Science Direct and PubMed.

After the literature study in which the conceptual framework was designed, qualitative research methods were used (Verschuren & Doorewaard, 2010). The qualitative research methods chosen for this report were focus group discussions and semi-structured interviews. Qualitative research methods suited this research since the aim was to explore different views, beliefs and experiences (Powell, 1996, p499). A focus group discussion is a method for qualitative research in which the researcher introduces topics or certain issues into a selected and assembled group of participants with the aim to discuss and comment on these topics or issues (Wong, 2008; Powell, 1996). This method was chosen since it offers an extra dimension, above individual interviews, in providing interaction among participants. The participants were encouraged to discuss with each other and to comment on the others' points of view. Furthermore, focus groups provide a tool for exchange of ideas, views and beliefs (Wong, 2008; Powell, 1996). Focus groups can be used to gather information on perspectives on and attitudes about topics under research. Attitudes and perceptions can even be developed during the focus group discussion; this is due to the interaction with other participants (Krueger, 1988). For this research focus group discussions provided a useful tool for exploring the concepts of trust, altruism and reciprocity since these concepts required discussion because they were abstract and complex (Powell, 1996, p500).

From the conceptual framework, sub-questions were derived that guided the interviews. These sub-questions were operationalised into topics for the discussions. A total of five focus group discussions were held. The session started with the vignette of Ms. Meltafa to start the discussion,

see box. This vignette was played on a laptop or screen. On beforehand participants were asked to watch this video and form an idea about the vignette. The vignette was useful since it provided a good example of an altruistic act of one person; she sacrificed time, money and energy on a court appeal that benefitted others. Ms. Meltafa's grant, that she received for her sick child, was suddenly stopped by the government. She was offered an individual compensation from the government. She could have taken this compensation to solve her financial problems immediately. However, she refused this and went to court because she found out that other people experienced the same withdrawal of grants. Her appeal became a case that represented all persons whose grants had been stopped, without formal notice. This case benefitted others by gaining publicity and opening up the debate on social solidarity. She refused a pay out in order to prove that her case was beneficial to others. Her rights claim can be seen as formulated in a more collective notion. Her action benefited a wider group of people with the same experience.

### ***The case of Ms. Meltafa***

***(<http://www.beatit.co.za/archive-documentaries/law-and-freedom-part-2-a-nice-country>)***

**Zackie Achmat:** South Africa has an unemployment rate of more than thirty percent. The poorest households in our communities survive on old-age pensions and grants yet the Eastern Cape government cancelled people's pensions without due process. Ordered by the High Court to reinstate the pensions and the grants, the Eastern Cape Government appealed all the way to the Supreme Court of Appeal in Bloemfontein. This case reveals how provincial government punishes poor people instead of corrupt officials.

**Nozolile Meltafa:** [I remember when I was suffering and this child was sick. I couldn't eat. It was very hard for me then. I was working for a big company. I had to travel far. I gave birth to four children. One died and now I have three. One is married and out of the house and another one lives in Pretoria. Their names are Ntombi, Nomphele and Nombulelo.]

**Nombulelo Meltafa:** [I started getting sick when I was in standard 5 or 6. I had problems with my health. My teacher would bring me home. Sometimes, when I was walking home from school we'd be walking on a straight road, but suddenly I would sway from side to side. Instead of walking through the gate, my mom would catch me crawling through a hole in the fence. That was when my illness started. I applied for a disability grant in 1978. I got the results in December. I started receiving the money in January 1979. In January 1979 I received a quarter of the money.]

**Zackie Achmat:** Twenty years later Nombulelo's grant was cancelled without a hearing.

**Nombulelo Meltafa:** [In March 1998, my mom went to the Department of Social Welfare. I was standing outside when I saw my mother crying. I asked her what was wrong and she replied, 'I didn't get the grant. They told me it's not available'.]

**Zackie Achmat:** The tradition of lawyers serving poor communities is an important part of our history. As a youth activist, Dullah Omar defended myself and many other young people for no charge at all. Dullah, our first justice minister, spent his life defending poor people, pass law victims and workers, very often his family went without money and Farieda, his wife, had to earn money by selling vegetables and fruit at the Salt River market. We need young lawyers, black and white, to continue this tradition of sacrifice and engagement some of these lawyers are today to be found at the Legal Resources Centre.

**Mzuphela Maseti:** I became aware that there exists here a position of a fellow for 2001 here at the LRC. When I was a student it was a place I aspired to be a part of. So I quickly drafted my CV and faxed it, and I still remember it was the 23rd November 2000. So I came for an interview and it was a hassle, I didn't have any money; I had to sell some of my things to make sure that I came for an interview. If you have regard for what was going on in the '80's, even though I was young, detention without trials invariably LRC was there to assist those who couldn't assert their rights then. Detention without trial for example, hangings at the time, people like Arthur Chaskalson he's a top notch lawyer, I mean, we're aware of them. He was also involved in the Madiba trial, so I was aware that this organisation was composed of people of high calibre who were aware of human rights.

**Sarah Sephton:** I just wanted to work for an organisation whose values I felt comfortable with and I didn't want to work for a commercial firm. I didn't fit in. The case started long before Mzu and I joined the LRC. But they started off doing individual cases on behalf of people whose grants had been cancelled and they noticed that there was just an increasing number of people that were coming to the LRC and saying, 'The LRC eventually realised that it was much greater than they had initially thought.'

**Nozolile Meltafa:** [I heard about the Black Sash when I lost my money. The Black Sash helped me until I got my money back from Home Affairs. People were telling me that the Black Sash would help me get my money back.]

**Mzuphela Maseti:** The Constitution section 32 states very clearly that everyone has the right to administrative justice. Which means, for example, that if you have to make the decision to cancel a grant: give reasons, inform that particular person of the fact that you're cancelling his grant. They didn't have regard to that.

**Sarah Sephton:** We went to court for Ngxuza, Meltafa, and two other people and we asked the court to declare that their grants had been cancelled unlawfully and that their grants must be reinstated with back pay and interest and costs of that application. But then we went on to say...to ask the court to give us permission for those four people to represent the class and the class were all those people whose grants had been unlawfully cancelled from 1 March 1996 to date, which was in September 2000.

**Mzuphela Maseti:** People were not afforded an opportunity to be heard, which is crucial. You are faced with a situation where people do not...where their only source of income is their disability grant. And you, at best, must inform those people that you intend to do this process

**Nozolile Meltafa:** [When I went [to the Department of Welfare] to find out if the grant was available, they said it wasn't available yet. Then I asked them, 'why?' They said you ask too many questions, because of your lawyers.' They said it to me, Nombulelo and Mr. Ngxuza. I was very upset but I didn't want to respond because my child was sick. They were very rude to us because they said we depended on our lawyers. I stopped paying attention to them because they said we knew nothing. I told them, 'I'm not fighting with you'. 'You were sleeping and I woke you up'. We received a cheque for R14, 000.]

**Nombulelo Meltafa:** [Sorry, didn't we get a cheque for R1, 000 for two months?]

**Nozozile Meltafa:** [No, the cheque which we took to the lawyers.]

**Nombulelo Meltafa:** [Oh, that first cheque for R14, 000 that we gave back.]

**Nozozile Meltafa:** [They asked me to call Nombulelo to sign for the money. What did they say?]

**Nombulelo Meltafa:** [They said, 'don't bother us again'.]

**Sarah Sephton:** Department officials went with local political...local politicians and pressurised these people to accept the cheques and what happened is Mrs. Meltafa and Mr. Ngxuza arrived at our office with these cheques for.... I think Mr. Ngxuza's was in the region of R44, 000.

**Nombulelo Meltafa:** [After we received the cheque, Sarah said, 'if you want to use the money, you can. But you must know that you might not get another cheque next year.' My mother replied: "Nombulelo's grant problems are in your hands".]

**Sarah Sephton:** And so all four of them didn't hesitate in saying, 'no we're not accepting the offer. We

understand that there is going to be a delay for us and it will be some time before we get our money but if it's going to help thousands of other people we're fine in not accepting that offer'.

'hey my grant's been cancelled. I don't know why. I wasn't given any notice. I wasn't given any warning'.

**Nozozile Meltafa:** [There are many people who are afraid to get help, because they are scared of being ridiculed. Even with me, people I didn't know would say, "there goes Mrs. Meltafa, the one with the lawyers'.]

**Sarah Sephton:** Obviously we were delighted with the Supreme Court of Appeal Judgment.

**Nombulelo Meltafa:** [I still get my cheque deposited in Standard Bank. And after that?]

**Nozozile Meltafa:** [That was the end. This is the man who gave me freedom: Mandela. I have the right to go to lawyers. Mandela has done good things for us. Now we have the right to change anything that's wrong. But don't be silly. You have to challenge it properly, with respect. We are very happy with the way things are going and we want it to continue. But there are still people who are not accessing their grants. Don't worry about what people think. Do what you have to and move forward.]

**Sarah Sephton:** I'm going to read from the Supreme Court of Appeal judgment where Judge Cameron says, "all this speaks of a contempt for people and process that does not befit an organ of government under our constitutional dispensation. It is not the function of the courts to criticise government's decisions in the area of social policy but when an organ of government invokes legal processes to impede the rightful claims of its citizens, it defies the Constitution which commands all organs of the state to be loyal to the Constitution and requires that public administration be conducted on the basis that people's needs must be responded to'.

**Nozozile Meltafa:** [It has been a beautiful change. I'm glad that the change happened now. At least now I can rest.]

Focus group sessions were held within different Non Governmental Organizations (NGO's) joined in the Learning Network. The sessions were held within Ikamva Labantu, Epilepsy South Africa, The Women's Circle and Women on Farms subsequently. Within Epilepsy South Africa two sessions were held; one with social workers and one with beneficiaries. The NGO's were chosen for their experience in working with human rights topics. All participants, of both gender, came from local communities situated in the western cape of South Africa, e.g. Cape Town and suburbs or surrounding villages. The focus groups were arranged by approaching the contact persons of the organization by telephone or email. Participants were asked to speak English, since everyone was able to speak this language. Although English was not always their first language, for the sake of the speed of the discussion in the focus groups, this language was preferred above translation, which would slow the process down. One focus group was conducted with both English and Afrikaans speaking participants who translated the Afrikaans into English. Each focus group discussion consisted of 5-12 participants. All sessions were voice recorded with informed consent on

beforehand. Consent forms were explained to all participants before they signed the forms. Confidentiality was insured by making the names of participants anonymous and storing records in a safe place. Before starting with data collection ethics approval from the ethical committee of the University of Cape Town was obtained.



Fig 4. One of the research locations where a focus group discussion was held

After the focus group discussions one semi structured interview was held with a professor in Public Health; a member of the Learning Network. The same topics, derived from the conceptual framework, were used. Besides this, the preliminary findings were discussed, which provided an opportunity for reflection and deepening. Semi structured interviewing provided a useful tool for discussing the concepts, because it offered the opportunity to explore the concepts in detail by reacting on the answers of the interviewee (Britten, 1995). Consent for voice recording was given on beforehand.

Besides the data out of the interviews, notes on the process of the sessions were taken, which were used as an extra source of data. Furthermore, interaction with social workers and neighbors who were around after focus group sessions turned out to be a useful source of data. These were a form of observation which was written down as a memo after the visit.

### **Method of data analysis**

Data analysis was done by transcribing the tapes of the focus groups discussions and interviews. After transcribing each transcript was read through thoroughly and compared with the handwritten notes. The transcendental realism theory of Miles and Huberman (1994) was used in the data

analysis. This theory consists of different interwoven components; data reduction, data display and drawing and verifying conclusions, see figure 4 below (Miles and Huberman, 1994). Since the data analysis is an iterative process, the steps explained below were not chronologically taken all the time.

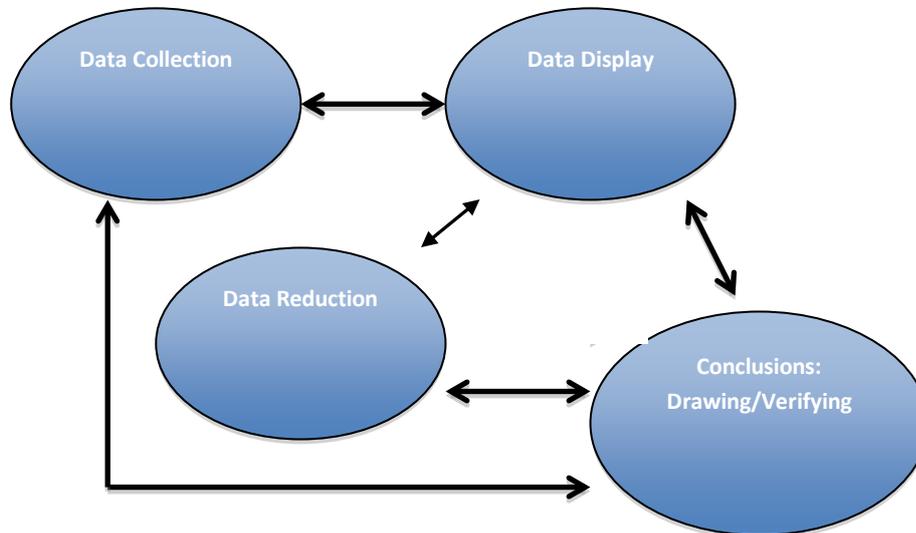
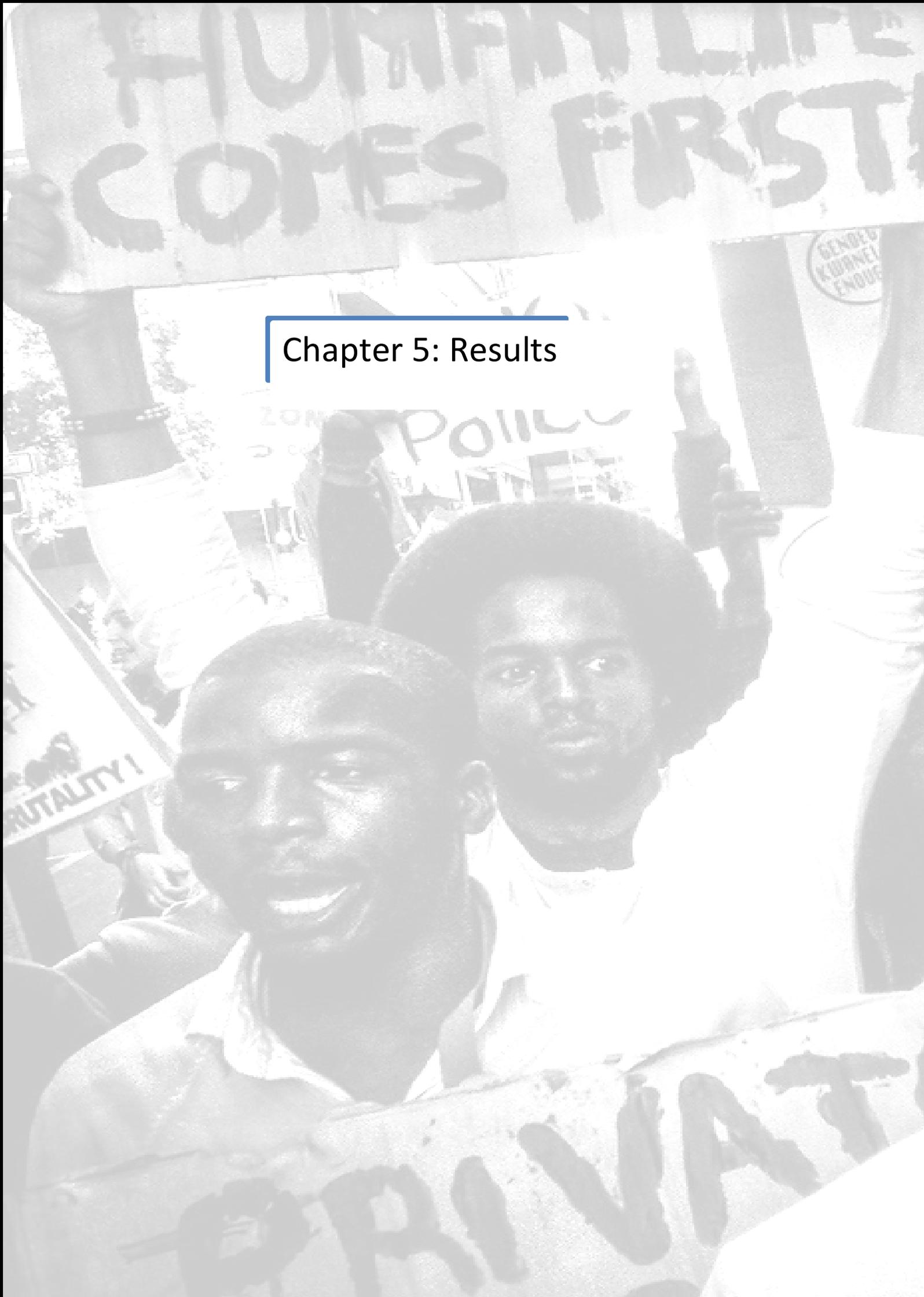


Fig 5: Components of data analysis; interactive model (Miles & Huberman, 1994)

Data reduction was a continuous process throughout the whole research with the aim to reduce the data into a manageable size without losing significant information. It involved actions like segmenting, summarizing, coding, memoing and finding themes and patterns (Miles and Huberman, 1994). In this research the data from the transcripts were first reduced by coding. From the conceptual framework codes were derived. The transcripts were read thoroughly and concepts that arose were first basically coded with the codes from the conceptual framework so broad themes came up. Since the conceptual framework was used only as a tool open for revision, other themes or concepts that arose from the data were labeled as well. After basic coding, advanced coding was performed which lead to a higher level of abstraction and a categorizing of the data (Punch, 2005). The codes were summarized into matrixes that provided a clear display of the data; all useful quotes were displayed per session.

After this, the drawing and verifying of conclusions began. The matrix and memo's were the sources in this process. Verifying of conclusions was done by discussing the findings with lecturers, co-student and professors at the University of Cape Town and VU University.

The full interview guideline with topics and questions, used in the focus group discussions and interviews, is provided in appendix 1.



## Chapter 5: Results

## **Chapter 5: Results**

### **Introduction**

In this chapter the results of this research will be displayed. Each concept (trust, altruism and reciprocity) will be touched upon, after which collective action and social solidarity will be explored. During the focus group discussion the analytical division between concept was maintained, therefore the concepts will be discussed separately here as well.

### **Trust**

During the focus group discussions participants shared their experiences and ideas about trust. A feeling of mistrust in others and in society lingers in the back of participants' minds. As one of the participants in the first conducted focus group stated; *'So there is no trust or whatever, you can't trust nobody; You can't trust your husband, you can't trust anyone these days. (..) even me, you can't trust your problem to me'*. When it comes to expecting that others will stay true to what they believe one of the participants said; *'I also think that people are easily swayed'*. She mentioned that people change their viewpoint easily when someone comes and tells them to do so. Furthermore, she mentioned; *'I think that many people in South Africa, and especially now, they think that people are taking advantage of them'*. She refers to the political climate in which she feels that there is no deliverances of the promises. A social worker recognises this in her work to provide the community with information for a healthy lifestyle; *'sometimes people do use you for their own benefit. Our community is illiterate, ignorant. They won't come for information. It is all about, oh there is food? let me go there. That is the kind you get'*. Another example of taking advantage of others is mentioned by a participant who talks about friends who deliberately stuffed his pockets with drugs so the police would arrest him instead of themselves. Participants do not believe that others keep their promises; *'they don't keep promises, they just speak'* and *'it is all half truths'*. They feel that it is a habit to not deliver on the promises made.

#### *Trust in strangers*

An anxiety and feeling of mistrust for strangers was mentioned during the focus group discussions. Participants in the first focus group mentioned that non-South Africans brought in the drugs and criminality. In other focus group sessions this was heard as well. *'Other countries, not from South Africa. The time when not anyone could come this way, to this country, there is no drugs. With only South Africans, we have no idea for the drugs. The time when we had freedom, every people could come here, and now there is so many drugs'*. Participants were asked how they defined a community and whether they felt that people from different communities could rely on each other. In all the focus groups a community was considered to be the people you live with in a particular area, with

their own structures and group norms. Participants of various focus groups said that different communities can't rely on each other, as one of them stated; *'because you know people are coming from different backgrounds'*. This is seen as a reason not to trust the other since they feel that there are still people fighting nowadays. As one of the participants stated; *so there is no, the solidarity is lacking very, very much'*. A participant from a community of coloured people felt this way: *the white people don't want to change. They don't want to live without that old [Apartheid] rule'*. He referred to the Apartheid policies here. The main reason put forward for the fact that communities can't rely on each other is that it is everyone for themselves. One of the participants believed that in the traditional society the concept of *Ubuntu* caused a strong bond. He explained this concept as follows; *'you are who you are because you are somebody in a society'*. So the relationship with others is as important as what you do. However, this strong *Ubuntu* feeling has been broken down by modern, urban, culture which encouraged everyone for themselves. Another participant disagreed; she felt that communities do stand together if they are asked to. This can be in case of a murder when different communities stand up together and march for attention (make a *toi toi*). Participants were asked how a good relationship between people who have been fighting can be established. One of the participants stated; *'but in a way you have to surface the differences first in order to get passed. If you don't surface the differences then you're always stuck'*. An important part of this would be to acknowledge that there were differences in power, status and wealth. However, others felt that it is difficult between communities since there are always individuals who feel different and who don't want to commit to the greater society; *'even though Apartheid is gone, there is so,( ...) ehm. I am better than you, I am living in a better community so why should I help you?'*

#### *Trust in the government*

When it comes to trust in organisations, the government especially is seen as an institute where no deliverance of promises is present. *'Trusting is that, there is supposed to be trust in your government'*. Promises of jobs, a good health system and education are not delivered according to the participants. *'You've got a system of education here, how many graduates are there? But they don't work, there is no work for them'*. Corruption was mentioned as an important factor for a lack of trust, as one participant stated; *'yes they are corrupt. So they are not assisting the people on the ground. Only the people who have got money'*. Participants feel that the chancellors just serve their own family and friends. *'They are not honest to us, from the top there is just no trust, no, from the top right down'*. Furthermore, they mentioned that there used to be trust in the government after Apartheid, but this trust has faded away; *'because we fought for this freedom. And we used to trust them. I think the main problem is also the, ehm, the system is very much to the criminals now'*. They talked about the ANC government and said that these people used to be trustworthy first, but

nowadays not anymore. People don't know where to go with their problems. Politics are therefore not a subject in which people are interested in nowadays; *'people lost hope, people haven't got confidence in the government anymore. Our people say no to politics, our people don't want politics'*. Some feel that many people don't take the opportunity to vote because of the feeling that it won't change anything; they don't see the use anymore. One of the participants indicated that it is not necessarily the poor people who don't vote, because this population is targeted mostly by politicians; educated individuals are not voting as well since they see the corruption.

### **Altruism**

During the focus group discussions participants were asked to tell whether they felt that people just look out for themselves or do things to benefit the whole community. Participants in every focus group agreed that most people just look out for themselves. An example of this would be community members who serve in government boards and only help their own families out; *'for instance if there is a contract, and I have a contract then I will only put my family there. I don't put other people in the community that is in need for a job, I don't take them. As soon as I get a tender, I will take my family'*

Only a handful of people would do things to benefit the whole community according to participants; *'it would be people that are passionate about the community, that are passionate about whichever group or community they are helping (...) but very few yes'*. Another participant thought that it varied, since in a big society people are more likely to look out for themselves but within the family they tend to look after each other. He also said that *'within circles they would do things for friends that they wouldn't do for other people'*. A distinction between urban and rural areas was made as well; in rural areas, participants said, people are more willing to do favours for others. Whereas in the urban townships, where people live in the same overcrowded areas under the same hard circumstances, no empathy for each other is shown when it comes to robbing each other. When participants were asked whether they felt that people mean well in general, a similar feeling was displayed; *'not all the people, there is not a lot of people, there is a people who make the right thing. But there is another people who don't make a right thing'*. Furthermore, one participant remarked that it is hard to believe that others have goodwill if you don't trust them. The feeling that people are meant to help each other was mentioned as well, linked to an example of helping someone out in need. In this example the community helped out a women whose house was burned down, by providing her with clothes and food. They mentioned not to want anything in return for this act. The following example also shows that the feeling of doing the right thing is strong;

*'There was some lady, old lady there, I can't name her. Their son was shot and then he died about then. They shot him. But the community stand up and give them hundred Rand, hundred Rand, hundred Rand (...) And that women didn't pay us back because we don't expect that'*.

Participants were asked if people help others out without expecting anything in return. They agreed that only a few people do this; *'there is people that does that. But there are others that will do something for you, but then you are on the owe-list'*. By owe-list she meant that people will remember the favour and ask for a settlement of the debts on a time convenient for them. Another participant said that sometimes people will do things for others without expecting anything in return, but this depends on context and the circle they live in. This is something others have mentioned also; *'I'm sorry to use this language, but.. well, the people who've got money can't help the poor people. So the poor people help each other'*. When participants were asked about helping a stranger out, most of them said they would do this no matter what, since this is the right thing to do; *'no matter what, I'm going to stand up for him, no matter he is a brown or white men'*. However, a participant shared his experience with helping someone out that did not turn out as planned: *'I saw two people fighting. I went to go stop them, (..) He went around the corner and went for his friends. So they shot me and they stabbed me'*.

Participants believe that people are not willing to sacrifice a lot of money for others since most of them experience financial problems themselves. People want to see a return on their investment, so sacrificing money isn't done on a large scale. Sacrificing time might, on the other hand, be done depending on whether the other shows that he really wants to be helped; *'So, if I take that help and make use of it I think somebody will go to the end with you'*. An example of a low willingness to sacrifice was brought up. It showed how people with resources were reluctant to pay a higher rate for government redistribution policies that would help the poor citizens living in townships. Participants feel they owe something to the community, however they feel they don't have enough resources or power to really make a difference. They acknowledge playing a role in making sure others get their rights; *'you can stand up for other people. Because they don't know what is going on'*. One of the participants mentioned that this can be on a small scale as well, like an advice or discussion with friends.

### **Reciprocity**

During the focus group discussions participants were asked if they expected something in return when they did someone a favour. Participants in the first and third focus group agreed that they did not want something in return since they gave this favour to someone in need, out of a feeling of doing the right thing. However, one of the participants mentioned that she wanted to return the favour if she would have received one; *'what you benefit at the end of the day, you have to make sure that you are ploughing back for other people who are poor, (..), more than you.(..) Even if you do not pay back by money, then you do some other things in the other community'*. Different reasons for

exchanging favours were mentioned. Some participants said that doing favours arises from love for others and from passion. Other participants mentioned that exchanging favours is a way of getting in one another's good books and to be favoured yourself; *'you might have something extra that you might not need know and you can translate it into something that you might benefit from later'*. One participant admits that she wants to be recognised for what she did. Another reason was the feeling that they owed a particular person something because of the relationship with that person. Participants were asked to what extent people are willing to help others if they know they will be assisted in return. One of them answered; *'I think they will go extra hard if they know that they will benefit'*. Furthermore, another participant stated *'it's almost like the effort equals the benefit'*. She meant that people will put in extra effort if they know something good is involved. Another participant disagreed with this, she said that doing favours must come from the heart and not out of expecting something in return. One of the participants added that time plays a role as well; *'you might help somebody now, but you might need to wait for a long time to get the benefits'*. An example of this is families who save money to send their children to university on the basis of that these students will be able to support the whole family after graduation. This participant said that returning the favour is something that happens within circles of people who are trusted and not as much between people who aren't kin or friends. Helping someone out who did you wrong in the past is something not everyone would do. For example one of the participants mentioned the governmental institution; *'I'm sorry to say to you, if it is somebody who was in the government. I can't make any favour for him, because they did not make any favour for us'*. Another respondent said that one should not generalise and say that no people will turn around and help someone who did them wrong; *'because there are lots of forgiving people in society'*. When people see that someone has changed and is doing the right thing, they will forget about the past and help this person out. As one of the participants explained; *'that time I will become the good Samaritan (..) I don't see the differences, I just help him'*. Participants were asked whether they felt that people would do things to benefit the whole community. As an example the neighbourhood watches were given; people within communities who get together and protect their environment and look after each other. One women stated; *'there are people that do things to help the community as a whole. But that is also a struggle, because, as I said there is always one that is turning away'*. Meaning that it is difficult to unite everyone. A different example was mentioned by a participant who stated that nowadays children grow up without a role model and everyone has a task in teaching them; *'there is not that atmosphere in the home. It is other people out there that learn your children like that (..) Other people come to my door and say your son is doing like that you must watch out for the others, do you understand?'* If everyone teaches the children good behaviour, a community becomes a better and safe place.

### Social solidarity and collective action

The focus group discussions started with showing the vignette of Ms. Meltafa (see chapter 4). Participants were asked what they thought of this vignette. Some participants felt that she was smart and brave. Another one stated; *'my opinion is that it does not always happen like that in our communities. But if our community or*

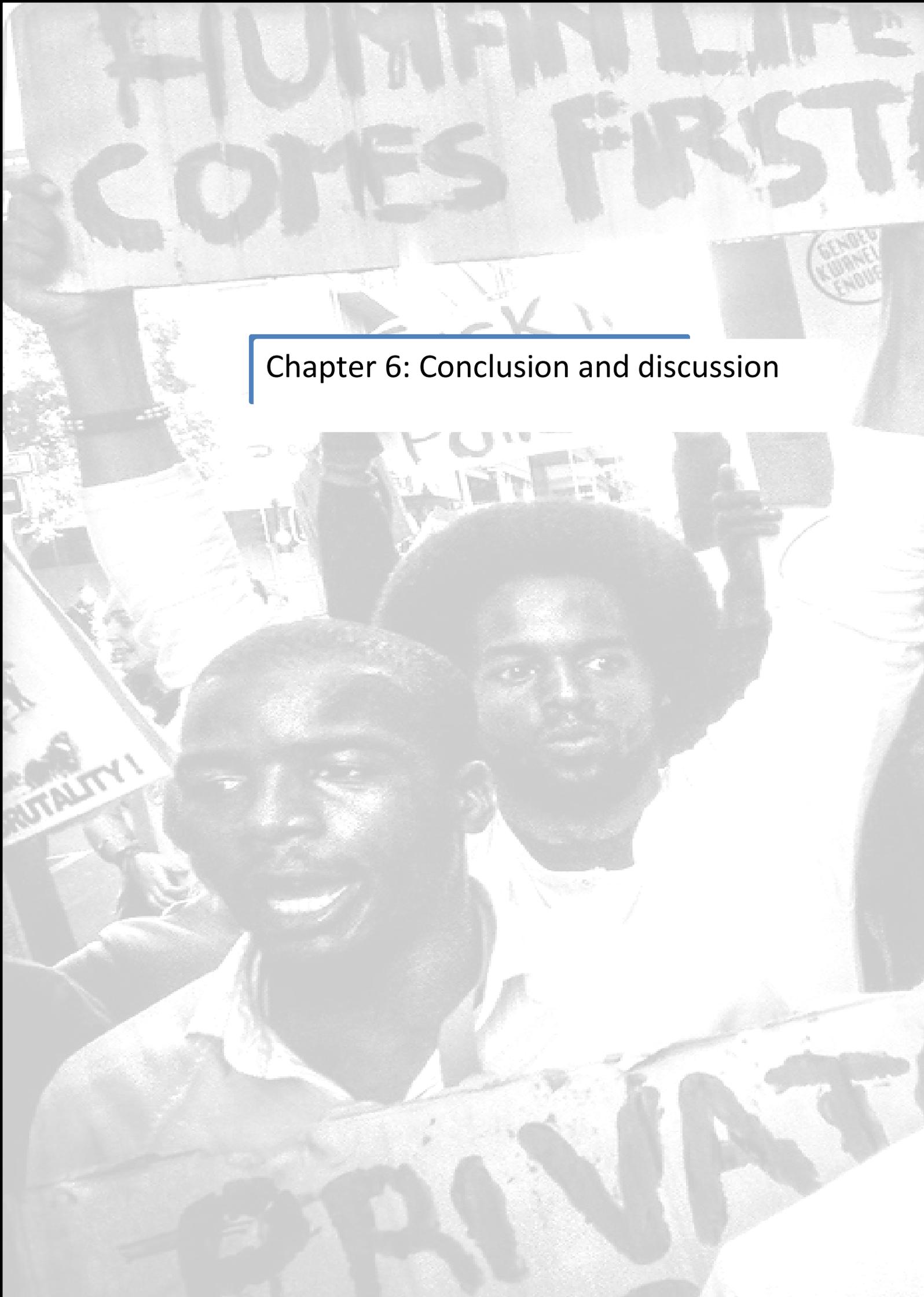


Ms. Meltafa

*our people could do the same thing (..) it would help a lot for people who are being treated out of their rights'.* They mentioned that a lot of illiterate people don't have knowledge of their rights and have nowhere to turn to for information. Furthermore, one of the women stated; *'the women are not empowered in our community to stand up and say we are going for a whole group and to stand up for our rights'.* They did, however, acknowledge that everyone is entitled to equal rights and that women do not have less rights than men. The importance of collective action was acknowledged by all participants; *'if we can work together, all of us, South Africa would be beautiful. Nobody gets crime, nobody can sleep in the street, nobody can smoke the Dhaga (marijuana) and taking the tik (methamphetamine)'.* The problems with drugs and crime were subjects that returned in most discussions. Participants indicated that they were afraid of being robbed. Especially among the younger people, the problems are the worst. A lack of jobs is causing them to hang around and leads them into drugs or alcohol abuse according to the participants; *'you've got a system of education here, how many graduates are there? But they don't work, there is no work for them'.* Participants also mentioned that nowadays each person deals with his own problems instead of working together to solve a certain common problem; *'we've got a divided community that is a fact and that is the truth'.* People don't form a united front and do not speak with one voice. One of the participants admitted that it is difficult; *'it is about collective action at the end of the day, but how do you get people to realize that collective action would work'.* Another participant stated; *'it depends on how bad they want the situation to change. So people will stay united for a special purpose, and then when it is fulfilled, they disperse'.* She added that it shouldn't be discredited what is already happening in communities where people do rise to the occasion when they are called upon. An example of a health clinic was given, in which there were different cues for HIV and TB patients which was a violation of patient rights for HIV/AIDS patients. Community members stood up against this distinction. Another example are the neighbourhood watches; community members who take the initiative to watch over and to protect the community. Despite these kind of examples, one of

the participants stated: *'they are comfortable and they don't see the need to actually join forces'*. She thought that people don't see that working together will benefit them, and that they might be scared of losing what they have. Furthermore, another participant thought that people feel tired and are sitting back and wait for their rights to come to them. Whereas in the past they did not have those rights and had to fight for them. Voting is not seen as an opportunity to get together and form an united front since people feel they won't be able to make a difference. Some participants mentioned that people are afraid of claiming their rights in government institutions since they will be sent away or shout at, and therefore they sit down and wait. A social worker indicated that people are empowered to claim their rights nowadays but they don't see any changes; *'they don't see any action so they just see that as something that's put on the wall to look pretty and what is not implemented at all'*. Participants were asked what they thought would be needed for people to engage in collective action. Different opinions came up; some felt that collective action should be based on trust and love for others. Others mentioned that people should be able to make a commitment to society as a whole, like Ms. Meltafa did when she didn't accept the settlement but stayed on 'the process train' for everyone else; *'she thought staying on the train would help everyone (..) so, that's the sort of key thing that staying on the train is the right thing to do'*. Furthermore, honest communication and empathy for one another were outlined. One of the participants stated that people need to be mobilised, but that this is not easily done in a divided community; *'there must be someone who drives it. It is not going to happen just like that. There has to be someone who is strong enough, or people who are strong enough to try collective action'*. A driver can be someone who advises or teaches the community about rights and places where rights violations can be reported, according to other participants. One of the participants, from a coloured community (participants identified themselves this way), mentioned that communities can learn from each other since they experience similar issues; *'we need to network, with others, like the black communities, we need to invite them to come and maybe strengthen us, to empower us'*. This participant added that Africans stick together whereas the coloured community is too scared to stand up; *'our coloureds, they don't want to stand together. Like now, with the shootings and gangsterism. They are too scared to raise their voices'*. This idea was present in a different focus group as well: *'people are supposed to come together. When you come together you mustn't fight, (..). You must talk (..) we don't have to only be brown people'*. In another focus group an example of communities who help each other out was given. *'Say for instance somebody was murdered and the community stands up and marches. We will ask Wellington and Paarl, the communities nearby, to assist. So I think that some of the communities do stand together if they are asked to'*. Another participant mentioned that community members should engage in government institutions and serve in boards for decision making. Community members know what is needed in their own community, whereas politicians come and go according

to her. But community members must be reached first according to another participant; *'people will change their mindsets. Especially when you go out to their homes, (..) when you explain to them, make them aware that there is hope, that there is help, then they will come'*. Another participant added that the government is quite hostile towards civil society action and collectively organised meetings are seen as trouble making. Therefore civil society is not an accepted place to be in nowadays.



## Chapter 6: Conclusion and discussion

## ***Chapter 5: Conclusion and Discussion***

### **Conclusion**

This research, situated in Cape Town and surroundings, provided an insight in different views and beliefs of individuals linked to the Learning Network on concepts of social solidarity and social capital in the context of collective action. The question what are beliefs and views of trust, altruism and reciprocity in the context of social solidarity for collective action in rights claims and how can these concepts contribute to collective action was explored. Trust, to start with, can contribute to collective action if individuals in society are willing to use and install it. Important in this regard is that trust should not only be used within their own community or for friends and family, but also within larger society and for strangers. This derives from the recurring subject of social distance and anxiety for strangers. Putting trust in strangers can contribute to a feeling of solidarity and can reduce social distance; both needed for society to stand up and fight collectively for their right to health. Trusting others can help overcome differences and problems of the past. Furthermore, trust was seen as a basis for the other concepts, which shows the interrelatedness of the concepts. Social distance and an anxiety for strangers were also during the discussion about altruism. Altruistic acts were believed to be only performed for people within close circles. Altruism was found to be important in collective action since it can contribute by reducing this social distance. An altruistic act will lead to a stronger feeling of solidarity and therefore a greater willingness to commit to others. Altruism is needed to strengthen the intercommunal bonds; not only members of the same class or community should help each other out, also different layers of society should be willing to perform an act of altruism. Since this might be too much to ask at this point in society, bonds can start to develop using reciprocity. This research showed that reciprocity is considered to be the best option for collective action for rights claims. To achieve the right to health and to provide everyone with a standard of living adequate for the health and well-being of himself and of his family, reciprocity, which must include a bases of trust, can be used for the redistribution of resources. Favours and sacrifices made, can be reciprocated to benefit everyone. Reciprocity can contribute to collective action if individuals reciprocate favours they've received, in the context of the right to health, to others. This can range from a small advice where to go when your rights have been violated, to contributing to a large health care scheme.

### ***Discussion***

Trust is needed for collective action, however this a matter of concern to most participants. As Luhmann (1979) mentioned, a trustor assumes that the other will not take advantage of him or change his opinions or beliefs. This assumption is not one that individuals feel they can make

nowadays; they feel that people will take advantage of them and that others are easily swayed. Individuals are not willing to take that leap of faith; they are not willing to put their trust in strangers and people outside their communities; an anxiety for strangers is visible. This is worrisome since trust, and also trust in strangers, is outlined by participants as a basis for collective action. Putting trust in strangers is difficult because it makes one vulnerable; one might lose what he has because a stranger's actions are not certain, and expectations cannot be based on former experiences with this person. A feeling of mistrust in other communities is present, fuelled by negative feelings of the past. This feeling of mistrust might not even be the worst feeling; it still means that a bond between two parties is there. Although this bond has experienced setbacks, it might be enhanced in the future. During this research, however, the feeling towards strangers or former enemies was not one of mistrust. A more severe feeling of indifference is present; indifference towards problems of others, towards contribution for the greater good, towards the welfare of others. This feeling of indifference is even harder to overcome than mistrust, since bonds between two parties are not likely to be established.

Trusting strangers might be too risky for the population in South Africa that has no resources at all. Trusting becomes easier when someone is doing well and can afford to take the risk now and then. The upper class of the South African society should therefore be encouraged to take more risk for the sake of the whole society. A practical example of this can be the willingness to support a national health insurance scheme that will help vulnerable groups with their health care costs. The anxiety for strangers is worrisome since it leads to a society in which people only trust their own kind, and where social distance becomes larger. This anxiety for strangers will also influence feelings of solidarity. The distinction in races and skin color is still used on a daily basis. Even in this report, this distinction returns in the answers of participants or in discussing the history of South Africa. It can be argued that social distance and with that, Apartheid ideas, remain visible and are maintained. The fact that this distinction is still made, and that it is considered to be normal, should be questioned in every social class or community in South Africa.

Simmel (1908) had a vision about solidarity and an increasing individualisation process that is still relevant nowadays. He thought that individualisation would lead to more solidarity since people would lose their ties with closed communities and start to identify with others not out of being part of a culture or group, but out of the feeling of belonging to the same, human, specie. However, individualisation has brought a different aspect to the South African society; people started to do things for their own sake only, without considering their group. This can be seen in people who try to enrich themselves over others. The open market and liberalisation added to this feeling, leaving the less advantaged behind without being identified or recognised as being needy. A new upper class has risen, an upper class that unfortunately pays not enough attention to the ones left behind. Feelings

of solidarity seem to be decreased due to this expanding individualisation. Although Komter (2003) stated that self-interest can be a motive for solidarity, feelings of affection and shared norms and beliefs are still necessary. Self-interest only will not persuade the more advantaged to contribute to an insurance scheme, since they know that the needs of the less advantaged are larger than their own benefits from it.

Participants agreed that trust is needed for believing in the goodwill of others and for a strong reciprocal bond. Without trust collective action through social solidarity will be hard to achieve between different communities. Different communities do not rely on each other which makes it hard to form a united front in case of violations of the right to health. Assuming that others share your values and beliefs is a step that individuals aren't willing to take. This step, however, would be key in bringing communities and individuals closer together. Differences in power and wealth status need to be surfaced before communities can begin to feel one. Individuals from different backgrounds need to acknowledge that major disparities in health status and access to health care exist, which causes a large proportion of society to be treated unlawfully. Only when a feeling of unity is present, trust in each other can start to develop.

When it comes to trust in governmental institutions, this research showed that individuals feel that trusting the government is too risky. As Bachmann (2001) stated, power shows similar efficiency as trust in reducing uncertainty in social relationships. These power relations can be used to question social structures. For communities this would mean that power can be used to question the current health care systems and behaviour of government officials. Communities can gain power through collective action or by involvement in decision making boards. When communities use power towards the government, they can influence the decisions at that level. This will diminish the risk since the government behaviour will become more transparent and expectations will be met. This way confidence in the government can be established again. The other way around, the government should make an effort to become more trustworthy and transparent. Corruption and unequal distribution of resources must be addressed.

Altruism was found to be important for collective action. Sacrificing something for others on a large scale, is however too much to ask at this point in society where only a few passionate people do things that will benefit the whole community. Because most people are struggling to get by, sacrificing money is too burdensome. The willingness to sacrifice oneself for others isn't present throughout society, especially when it comes to strangers. However, the feeling of doing the right was said to be strong. This feeling is even stronger when it comes to friends and family; people will go further for them than for others. Collective action on a small scale between friends and neighbours is already present; a friendly advice about where to go when someone's patient right is violated can be an example of this. For South Africa, this small scale collective action should be

extrapolated to society as a whole. As Sorokin (1950) stated; for a society to survive a small group of altruists is not enough, a society needs multiple, so-called, good neighbours who all donate a small contribution of love. In addition to this, this research shows that this 'good neighbourship' not only requires love, but also a willingness to sacrifice something for others. Individuals should act as a good neighbour to their fellow community members and to individuals from other communities as well. These good neighbours could help each other out when rights violations occur. This research showed that people are missing someone to turn to for information in case of rights violations; they need someone to inform them about their rights and their entitlements. A friend or neighbour therefore can pose a solution in this case. Furthermore, individuals will engage more easily in collective action if this is for friends, family or neighbours; they are willing to put in extra effort. Several of these small scale advices or pieces of action can develop into something larger in which a whole neighbourhood will be involved. If community members start to realise that what benefits the whole group is good for them as well, altruistic behaviour will stand a change.

As stated before, this research showed that reciprocity poses the best solution for developing collective action. Receiving a favour leaves one feeling obliged to return this, which enhances a bond between individuals. Although some participants said that doing favours must come from the heart and they don't want to see the favour returned, most of them agreed that people are willing to put in extra effort if they know they will benefit from it in the future. The return of the favour is something that encourages individuals to act for the collective good. When it comes to claiming the right to health, helping others will benefit oneself in the sense that collective claims are more powerful than individual ones. When this involves action aimed at government institutions or health care policies, multiple voices speak louder than one. When the differentiation of Sahlins (1972) is used, it can be said that generalized reciprocity is not a form of reciprocity suitable for the South African society. This type of reciprocity only works well on a small scale between individuals who are kin. For individuals from different communities the weak obligation to reciprocate is not strong enough to form bonds that are necessary for the solidarity feeling needed for collective action. Balanced reciprocity is therefore more useful in the South African society since this requires the direct exchange of a favour of the same value. The relationship between individuals involved is less strong than in a generalized reciprocal bond; however this is strong enough to form a bridge between communities. Benefits will be returned or passed on to other communities. For a good reciprocal bond to be established a base of trust is needed, this became clear in this research. As mentioned before, trust is still a point of concern in the South African society which makes individuals reluctant to engage in a reciprocal bond. If people can be persuaded to put in a sufficient amount of trust, reciprocal bonds that will strengthen solidarity and collective action will result. People need to be convinced that what they contribute will be returned in an equal way within the

proper timeframe. Furthermore, the existing feeling of negative reciprocity in which others try to gain at the expense of others must be diminished. This can only happen with good experiences that overrule the bitter taste of previous bad experiences. The reciprocal action in South Africa did not always lead to a better society; the negative form of reciprocity was also seen in the form of revenge. In this form, communities, who felt they were maltreated, or who's families were hurt, engaged in collective action. However, this type of action was less moral and aimed at returning the maltreatment or the violence. So, when reciprocal bonds are to be established, this kind of negative reciprocity should be avoided.

As an example of collective action neighbourhood watches were mentioned. This example indicates a feeling of bonding social capital, as defined by Woolcock (1998), since this kind of collective action happens within a closed network of only community members who watch out for each other. Members protect the community from suspected danger from strangers. Bridging social capital would be a better option since this will connect different types of groups and could therefore reduce anxiety for strangers by including the groups who are seen as strangers. This research showed that this kind of social capital is needed between communities; it was mentioned that community should network and exchange ideas and solutions for common problems. This would be a form of bridging social capital that will foster collective action, in which communities learn from each other. It fits in with a human rights based approach to health which underlines concepts of equity, equality and non-discrimination. However, this research showed that discrimination is unfortunately still present and communities are reluctant to bond and form bridges. At least recognition of the fact that communities need each other to solve common problems is on the way, which shows positive signs for the future.

For establishing networks, the need for drivers was mentioned in this research. Communities need passionate individuals, who are trusted and respected, who enthuse members to be involved in collective action. A driver can advise and teach a community about rights and rights violations. Every community already has a driver or spokesperson among them, however this person's role needs to change into someone who encourages the members to stand up for themselves. Since this research showed that people nowadays tend to sit back and relax, someone must be there to wake them up. Before the first elections in 1994, a large amount of civil society action was present for bringing down the apartheid regime. Nowadays people feel they have their rights and these rights will come to them. Individuals must acknowledge that they still have to fight for them, and that they have to do this collectively. The negative atmosphere created by the government isn't helping; civil society members are seen as trouble makers. There is role in bringing people together that civil society should fulfil because the government can't fulfil this. This research showed that people start losing their interest in politics because of the negative sphere of corruption, consumption and egoism.

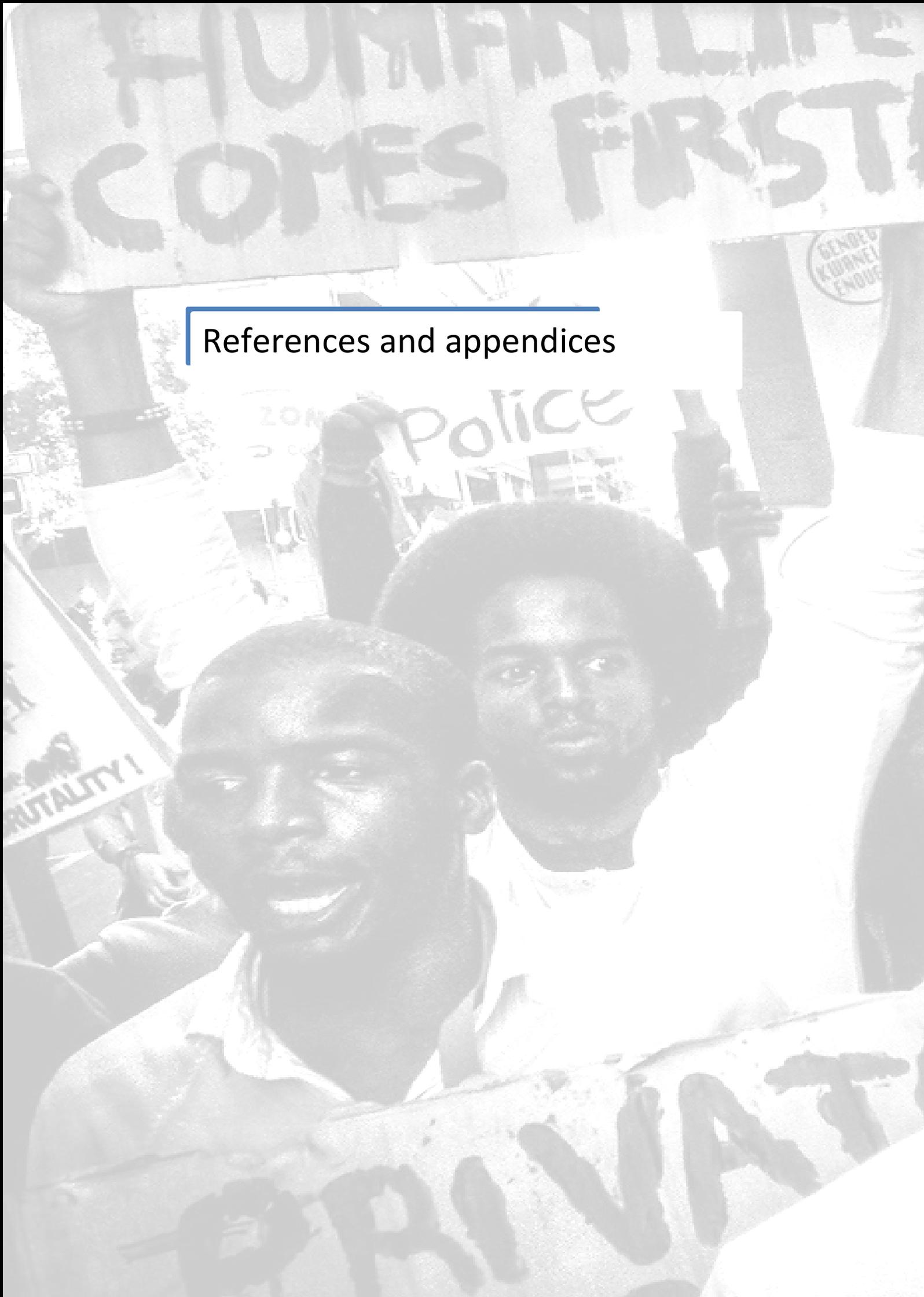
However, if local community members would participate in government boards and decision making, local support would be larger. Unfortunately in cases where community members did get a place in government institutions, only family and friends were assisted instead of lifting up the whole community.

This research was situated in the Western Cape; Cape Town and surroundings. The answers of participants were based on their own experiences in this particular area. Therefore, this research can't be extrapolated entirely to whole South Africa since most members do not have knowledge of living circumstance of their fellow citizens on the other side of the country. However, problems in the Western Cape are known to be present in other areas as well, which makes this research relevant for other provinces. This research has his limitations in the data collection. Participants might have felt that they could not speak openly about certain issues involving skin colour and racism since the researcher was a white person in a coloured or black community. However, most of them did speak out about racism and the difference between black, white and coloured. Since all focus group discussion were held in English, participants who were Xhosa or Afrikaans speaking, might have had problems with expressing themselves properly in English which is their second language. Interviewing in English was however considered to be a better option than a translator because the speed of a discussion would have been reduced enormously by translation. Besides this, the possibility of misinterpretation of the answers would be larger if a translator was used. Despite this decision, a translator was present during the focus group discussions with Xhosa and Afrikaans speaking participants. This provided the opportunity to express themselves in their own language, would they feel the need for this. The population of the focus group discussions was a mainly a population that lived in townships. One focus group consisted out of participants in the economical middle class. The mainly white dominated upper class of the South African society was not presented in this research. It is recognised that a focus group in this class would have provided different findings. However, since this research looked into collective action for the right to health, a population that faces a low distribution of resources and access to health care services was chosen. In some answers a feeling of socially desirability was present. This feeling can't be proven, but a critical reflection on this is therefore necessary. For example, in the answer on the question if people would want a favour returned if they helped someone out, most participants answered that they did not find this necessary. This answer could be called into question.

As pointed out in chapter 3 about the conceptual framework, the concepts trust, altruism and reciprocity are interrelated concepts. It was mentioned that the concepts can exist alone and provide a distinct meaning and working mechanism. However, the concepts are also depended of each other in certain situations. In this research an analytical distinction was made in order to reduce this complexity and to give more attention to the differences between the concept instead of their

similarities. The interrelatedness of the concepts can be seen in for examples answers of the participants; as one of them stated, trust is needed for altruism. For making a structured report, the distinction was necessary. However, the complexity of the relations between the concepts has been reduced which might mean that a deeper understanding of these concepts could have been reached if this analytical distinction was left out.

Although this research showed that negative feelings, towards the government, strangers and other communities, still exist, a positive feeling can be extrapolated from the findings as well. Recognition of the fact that collective action is important and that trust, altruism and reciprocity are facilitators of this action is present. This will form a stable base for solidarity in the future.



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## **Appendix 1: Guide for focus group discussion**

### **Setting:**

The focus groups with the beneficiaries of the LN will be held in a room in a public building or in an office of the civil society groups. The location must provide a quiet and comfortable environment. Refreshments will be provided. A convenient place will be searched for at arrival in South-Africa and after meeting with the supervisor there.

The duration of the focus groups is 90-120 minutes with a break of 15 min in between.

### **Introduction**

The moderator, Renate Douwes, will open the focus group and introduce herself, the interpreter (if necessary) and the record keeper.

*Welcome and thank you for being here today to participate in this focus group discussion. I am Renate Douwes, the moderator of today's session. I am a student at the VU University in Amsterdam.*

### **Aim of the focus group discussion**

The moderator will briefly explain the aim of the focus group session and the context of the research.

*'I've come to South Africa, Cape Town, to do a research as part of my masters education. This group interview will be used for this research on human rights claims. This research focuses on several things that might play a role, e.g. working together, trusting each other and relationships between people. I explain this so you will understand the type of questions I will be asking during this session. This research might help in explaining how working together can help in claiming rights to health. If people know that they have the right to good health and health care, they can claim these rights. Furthermore, if they act together in this claim, they might come further then acting alone.*

### **Informed consent and ground rules**

All participants will be asked to sign an informed consent form before the focus group session starts (See appendix 4). With this form consent will be given for audio recording and a declaration of participating out of free will is included as well. The moderator will explain the ground rules of the focus group discussion (Krueger, 1988).

*'First of all, everything said in the session will be handled with care. Privacy will at all time be assured, since sensitive information might be shared during the session. Your names will not be mentioned in the data display and will only be known by me and the researcher. Another important rule is that there are no right or wrong answers. I'm interested in everything you have to say, every experience, view or belief counts. Finally, since this discussion is audio recorded, it would be convenient to talk one at a time and mention your name before speaking.'*

### **Collective action and solidarity**

In this part the dvd with the case of ms. Melitafa will be shown or told. For the case see appendix 1.

- What do you think about this story?
- Would you have done the same thing that Mrs Melitafa did? please explain your answer
- Have you or your organization done something to work together towards a common goal?
- Do people have rights?
- Do you think rights are only for one person or for a group of people?
- Do some people have more rights than others?
- How do you define community? Can you give examples of your community?

### **Concept 1: trust**

- Do you think people in general will stay true to what they believe? Why do you feel this way?
- Do people from different communities in South Africa feel they can rely on each other? Why do you feel this way?
- Do you think most people would try to take advantage of you if they got a chance, or would they try to be fair? Please explain why you feel this way.
- Do people keep their promises? Can you give examples?
- How can a good relationship be developed between two people who have been fighting
- Do you think people trust the government in SA?

### **Concept 2: Altruism**

- Do you believe that people just look out for themselves or that they do things for the community? Please explain your answer
- Do you believe that other people mean well in general? Please explain why you feel this way.
- Do people help each other without expecting anything in return?
- How much of their resources, for example money, are people willing to sacrifice for others?

- How would people act if a stranger or someone outside of their community needs help?
- Do you believe that you owe something to the community?
- Do you think you play a role in making sure others get their rights?

### **Short break of 15 minutes**

#### **Concept 3: Reciprocity**

- Do you think people will return you a favor when you help them? Could you give examples of this?
- Why do people exchange favours? (e.g. own interest, to feel better, win-win situation)?
- To what extent are people willing to help others if they will be helped in return?
- What would you like to have in return for helping someone out who is in need?
- How would you act if someone, who did you wrong in the past, needs help?
- Do you think people will normally do things to benefit the community as a whole?
- What things do you think make it possible for people to work together?
- How can communities challenge the government when they want the right to health? What is needed?
- Give some examples you know of in which people worked together to claim their rights?

#### **Closing the focus group discussion**

*“The interview has come to an end. I would like to thank everybody for participating today. Your information will be very useful to the research. I hope you have enjoyed being part of this interview. Does anyone have any questions?”*

The recording will be ended 15 minutes after the meeting to make sure that important comments will not be missed